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To the Graduate Council of the University of Utah:

I have read the dissertation of Carl S. Miller in its final form and have found that (1) its format, citations, and bibliographic style are consistent and acceptable; (2) its illustrative materials including figures, tables, and charts are in place; and (3) the final manuscript is satisfactory to the supervisory committee and is ready for submission to The Graduate School.

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CHARACTERISTICS OF U.S. AIR FORCE MEMBERS WITH STEPFAMILY AND DIVORCE CONDITIONS IN SUBSTANCE ABUSE SERVICES

by

Carl S. Miller

A dissertation submitted to the faculty of
The University of Utah
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

Graduate School of Social Work

The University of Utah

December 2002

To [redacted] and [redacted],
your happy little spirits gave me hope to carry on.
To [redacted]
you waited, always showing me your love in the depths
of my struggles, and without your caring and
kindness I would be there still.

ABSTRACT

This study was an attempt to describe the characteristics of U.S. Air Force (USAF) members with stepfamily and divorce conditions who had received services from USAF substance abuse treatment programs. All available files from clinics at 3 USAF bases for the year 2000 were included in the sample of 330 members. Data were obtained from a record review, a survey instrument, and two focus groups.

An attempt was made to determine if characteristics of the sample groups were equivalent to the total population of the USAF, including the 3 Major Commands of each base's clinic. A comparison of sample characteristics with those in the general USAF population indicated equivalency.

Out of the sample, two types of family conditions were identified. The first type included members who had been divorced, or who had come from a stepfamily, or who had a stepfamily of their own. The second type included members who had never been divorced, who had parents who had never been divorced, or who had never had stepfamily circumstances of their own. The findings of the stepfamily and divorced member group were as follows: (a) They more often were given alcohol diagnoses; (b) they more often had histories of abuse as offender or victim; (c) they more often had less favorable attitudes toward helping professionals; and (d) they more often perceived barriers to seeking helping

professionals.

It was concluded that USAF substance abuse treatment clinicians need to be more sensitized and educated to the unique needs of members who have stepfamily and divorce conditions. These persons have needs that often may be overlooked by standards of practice in USAF clinics. This study was only exploratory, but the trends indicated the need for additional research in this area.

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ACKNOWLEDGMENTS

Although only one name adorns the title of this dissertation, I must concede ownership and honor those whose efforts actually produced this research. I gratefully recognize my committee chair, Bill Farley, who patiently focused me on concepts of simplicity; Jeanette Drews, who reminded me that I am dealing with very personal stories and feelings; Bill Dudley, who showed me how a one-handed clap sounded; Fred Janzen, who challenged every statistical notion I had (and won); and Jo Yaffe Kjosness, who persistently pleaded for clarity from me yet tendered each with kindness and professionalism. I wish to recognize my professional organization groups at the university's USAF ROTC unit, Hill Air Force Base medical group, and those who authorized my selection and assignment through the Air Force Institute of Technology. Beyond measure, I appreciate those who lent a friendly ear from my church and from my class cohort. Last, I applaud the women and men encountered as participants in the data collection for their willingness to share their experiences in the hopes of improving conditions for others.

I am exceedingly impressed with several realizations from the participants' efforts. I am astounded by the demonstration of extremely disciplined work from all of those mentioned. Not that any were incapable but that all were so personable and professional during the process, showing that this endeavor was more simple

than I first believed. I believe that I am on the verge of assuming immense responsibilities to adhere to the truth of events beyond what I ever thought was possible. I believe that our human condition is so common and shared that none is removed from each other's experiences in joy and pain. I believe that these simple ideas have affected me in profound ways that compel me to approach future research with humility and a sort of sanctity. I believe, then, that embarking on a search for the unknown must require audacity that is tempered with awe and respect for those being discovered. *Audentes Fortuna Juvat!*

CHAPTER 1

INTRODUCTION

Clinicians, researchers, and the general population have an insufficient appreciation of American stepfamilies. In fact, stepfamily members do not typically understand the complex and potentially debilitating issues that develop from their situations. Stepfamilies have an extremely high probability of subsequent and serial breakups. As such, adults and children developing in these environments may form maladaptive skills that result in distress at greater rates than nonstepfamilies. Huntley (1995), a prominent researcher, encapsulated the stepfamily dilemma:

> Due to their complexity, ambiguous roles, negative perceptions, and unrealistic expectations, stepfamilies are increasingly being seen by mental health professionals. Yet, . . . therapists continue to make assumptions about how the stepfamily should function based on nuclear family norms and expectations. This is inappropriate as well as potentially damaging. (p. iv)

Many authors have cited the increases in divorce rates and the subsequent swell of stepfamilies in the general population, estimating that sometime within the span of this decade (2000-2010) stepfamilies will reach and maintain majority status indefinitely. Estimates of stepfamily numbers vary sufficiently to confuse forming accurate descriptions. Even recent calculations are skewed by the available yet incomplete collection methods, and they do not entirely reflect actual stepfamily distributions. Diversity within the stepfamily forms matters in

understanding stepfamily types as well as in providing a basis for understanding how the members form identities. Remarriage, marriage into, or initializing a stepfamily carries automatic instability. Establishing and maintaining conceptualized boundaries and roles that recognize the insider and outsider status are crucial parts of stepfamily formation. The less willing to discuss resolutions that couples who come from previous relationships are, the more frequently they divorce and remarry. The degree to which the biological parent's role is legally and psychologically exercised within the stepfamily dynamic determines how well child functioning and development progress. Furthermore, remarriages are often hypothesized as incomplete social institutions. This attribution is because one of the most common barriers to researching the stepfamily population is comparison to the traditional family model. As can be seen, research content has contributed greatly to understanding and serving stepfamilies better; however, other stepfamily research areas remain unexplored.

Identified Population

Although general population stepfamily research estimates may be used to infer that stepfamilies outnumber traditional families in the U.S. Air Force (USAF), the current lack of USAF research on specific stepfamily issues indicates an unrecognized yet critical absence of knowledge. It is important to realize that stepfamilies may have distinct and critical needs. Relevant findings of general stepfamily research indicate that typical family stressors are intensified and compounded in stepfamily contexts. Family studies originating from the USAF

research community have seemingly, both passively and actively, chosen not to examine stepfamily issues separately from the traditional family model.

As such, studies explaining etiologies of USAF members' differences in conflicts by family types are few. Some military family researchers who have focused on causes of family conflict have concluded that military stepfamilies experience higher levels of intrafamilial stress due to rigid parenting and parenting belief systems than do intact military families. Other researchers focusing on family conflict effects of family members have found that marital dissatisfaction, low connection to outside activities and social groups, and personal distress rates were higher in stepfamilies and more often resulted in abusive family contexts (Adler, Pasley, & Pittman, 1998).

Notwithstanding the prevalence of distress in military family environments, studies explaining the relationship among USAF members seeking services are even fewer. One USAF researcher investigating barriers to mental health services found that two variables, embarrassment and weakness, often prevented members from seeking help (Stone, 1998). Other nonmilitary studies have reported that culture and personal finances are two prominent variables influencing decisions to avoid seeking clinical services.

As described by Daley (1999), military social work performs a variety of duties among the four military branches. Daley described the purpose of USAF social work as making significant contributions to the betterment of military service members and their families. He further related that, as the range of USAF social

work duties has expanded in the last 20 years, the need for ensuring quality standards of practice in newer practice forms as well as in traditional milieus have increased. USAF substance abuse programs, initiated by Public Law 92-129 in 1971, grew from a discretionary referral system to a mandatory system by 1980. The mandatory referral system removed a previously questionable diagnostic authority from the commander and placed it within the medical community. USAF social work duties fit well within these types of assessments. However, in all instances, the primary clinical consideration is the members' combat readiness or the members' ability to maintain their skills and personal abilities to contribute to a military action. Thus, the service provider has the key position to restore members and the USAF investment in them to operational status. Because this relationship is based on mutual trust, it becomes a primary factor in force retention and unit productivity. With this in mind, the service provider must consider the members' attitudes toward privacy and confidentiality, interpersonal and familial relationships, and career effects.

In order to further clarify the knowledge regarding the USAF patient population, a descriptive pilot study was conducted examining records of USAF substance abuse clinic patients having stepfamily and divorce conditions (Miller, 2000a). The pilot study data indicated that stepfamilies made up 64% of substance abuse clinic treatment patients for 1 year. The findings of the pilot study indicated how stepfamily members' clinic records do not specify how they came to be involved in substance abuse services or describe the family stressor antecedents or

barriers to clinical services. Thus, information was unavailable regarding prevention or specific treatment issues of the impact on stepfamily or divorce members.

In another pilot study (Miller, 2000b), four female spouses of USAF members were selected for a qualitative study to examine their experiences with low or high stress as mothers of their biological children or stepchildren. In two of the four stepfamilies, substance abuse was a factor in the breakups of their first or previous relationships. For one woman, substance abuse was the current cause of poor marital quality. Although all admitted past physically or emotionally abusive relationships, none admitted experiencing current family violence. Yet, all spoke at length regarding frequent and persistent conflicts with ex and current spouses in how to fulfill legal mandates and how to cope with each member's affect towards his or her stepfamily.

Theoretical Framework

Several theories have offered diverse explanations identifying stepfamily behaviors. Fine, Coleman, and Ganong (1999) offered a social constructivist, multimethod approach to understanding the stepparent role. Elliott (1997) advanced theoretical contributions from structural theory, psychodynamic theory, cognitive theory, attachment theory, trauma theory, narrative theory, and feminist theory. Fine (1997) used a policy model to explain how stepfamilies are portrayed and used to influence legal reforms. Evolutionary social scientists consider that instinctual parent and adult reproductive behaviors originated from environmental

adaptations (Daly & Wilson, 1998; Emlin, 1997). Each view offers insight to better understanding stepfamily dilemmas.

The present study adopted the social constructivist framework used by Fine and colleagues (1999). Payne (1997) described the integration of social work theory and constructivism, emphasizing that objective reality apart from social views of reality is not possible. This view differentiates positivism from social work theory. Phenomenological views within positivism propose that acceptable knowledge comes only from observational or experiential evidence. However, postmodernist components of social constructivism emphasize how power relationships expressed in language and worldviews create new meanings in order to raise social consciousness towards social change. The central concern when applying social constructionist views to problem causes is determining who composes the agreement between social theories of action and how it comes about (Payne, 1997). The result is a blend of diversity and complexity, which accommodates a reflexive perspective or the expressed relationship of mutual influence between ideas and social institutions. Reflexive social work theory applied to stepfamilies accepts knowledge apart from just observational and experiential evidence, thus allowing interpretation of the social power of family organizations.

The Problem Statement

Stepfamilies in the USAF have challenges and issues that are distinctive from the general stepfamily population. If handled alone, these challenging issues

may easily overwhelm stepfamily and divorced members' coping strategies and inadvertently place their family members at risk for conflict and breakup. Moreover, even as available as substance abuse services are within the military branches, the members themselves may pose the greatest barrier to seeking help. Members with stepfamily and divorce conditions may avoid formal services and seek self-defeating behaviors to manage their conflicts. If this is the case with such members, substance abuse clinicians have the responsibility to ensure that their scope of knowledge in treating their area of expertise is as fully developed as possible. In particular, clinicians with specialized skills for treatment of self-defeating behaviors should be equipped with more current knowledge about members with stepfamily and divorce conditions. Learning how USAF stepfamily members understand themselves, their conditions, and services provided for them will lead toward improving their probabilities of maintaining career stability and a healthy family.

Importance of the Study

The purpose of this research was to begin an examination of the impact of stepfamily and divorce issues among USAF members. This dissertation focused on an area of clinical service that is not identified, not researched, and not implemented within the USAF substance abuse treatment divisions. In an exhaustive review of the stepfamily literature from 1990 through 1999, no studies were found with a research focus that specifically or generally referenced stepfamily utilization rates of any counseling services whether the services were

mandatory or voluntary or specific or general in diagnosis. Overall, 452 studies were generated across legal, psychiatric, social work, education, and psychology as well as in other disciplines. All the articles met criteria identifying sample sizes. Yet, although stepfamily numbers in those studies could be guessed, none stated discrete stepfamily access rates or notions of possible relationships between stepfamily service utilization and avoidant behaviors. Whether this phenomenon is due to oversight or because of clinician perception of unimportance is yet to be determined.

Although stepfamilies may attain internal stability to some degree, they may do more from a self-imposed deficit comparison of recognizing what is not possible in their families and careers than from what may be possible. The prospect of this behavior may indicate that, as a function of marital and family composition, many members believe that there are more externally imposed (social and legal) limitations on their stepfamily identity development than nonstepfamilies might believe of their own. The stepfamily and divorce situation generally is not studied in the military; consequently, there is no formal information that military service providers actually know about the extent of the impact of stepfamily and divorce on current members. Researchers must first examine members' characteristics, distributions, and attitudes toward service barriers.

The present study examined for the first time the characteristics of USAF members with stepfamily and divorce conditions who are in outpatient substance abuse treatment services as well as investigated specific reasons why this

population may not seek help before such services are needed. Therefore, to gain a comprehensive understanding of the population, a descriptive method as well as inferential and qualitative procedures were applied. Thus, this study employed a three-pronged approach of investigating characteristics and relationships between clinical services and members with conditions of stepfamily and divorce. Although the term "substance" was used, only those individuals with alcohol-related problems were included in this study.

The Research Questions

This study was designed to answer the following research questions:

1. How many members with stepfamily and divorce conditions were treated for alcohol incidents in three USAF substance abuse programs during 2000?

2. What were the demographic, career, and clinical characteristics of the members with and without stepfamily and divorce conditions in the three substance abuse programs?

3. Did USAF members with stepfamily and divorce conditions who received outpatient substance abuse program services have equivalent characteristics to the general USAF population?

4. What were the similarities and differences between members with and without stepfamily and divorce conditions from outpatient alcohol treatment in substance abuse program services?

5. What were the attitudes and beliefs of USAF members with and without stepfamily and divorce conditions that indicated barriers to treatment in an

outpatient substance abuse program?

Study Limitations

The present study had two main limitations. First, the identified sample members received clinical treatment; thus, generalizability to all stepfamilies and those in the USAF is not ensured. Second, clinician note-taking styles differed by profession (e.g., psychiatrist or social worker) and by clinical specialty within each USAF clinic (e.g., substance abuse specialist or clinical psychologist). The variation of note-taking styles increased the difficulty in distinguishing whether or not members fit the study criteria and in extracting other characteristic data. The hardship created by those factors decreased the full range of discussion of some variables; consequently, they were not included in the analysis. Future research in this area should examine whether or not an impact on data collection would result from note-taking disparities.

Organization of the Dissertation

The study includes five chapters. Chapter 1 introduced the purpose of the dissertation that led to the research questions. Chapter 2 provides a survey of stepfamily studies that indicate unique issues and challenges examining general population data, clinical therapy issues, and the USAF population. Chapter 3 presents the research design, data, sampling procedures, data collection, data instruments, and analyses. Chapter 4 provides the results from the methods applied in the study. Finally, Chapter 5 summarizes the findings, relates them to the

framework, and makes recommendations for change in USAF clinical policies. Further research recommendations are also presented.

CHAPTER 2

REVIEW OF THE RELATED LITERATURE

Historical Overview: U.S. Stepfamily Data

Accurate counting is critical to examining clinical utilization; yet, substantial problems arise when referencing a census of stepfamilies. Historically, stepfamily counts have been sparse, and only in the last 20 years have serious efforts been made to provide valid, reliable, and on-going data collection (Pasley & Ihinger-Tallman, 1995; Phillips, 1997). Estimates of stepfamily numbers vary sufficiently to confuse forming accurate descriptions (Daly & Wilson, 1998; Ganong & Coleman, 1995; Huntley, 1995; White, 1998; Wilson & Clarke, 1992). Even recent calculations are skewed by the available yet incomplete data collection methods and do not entirely reflect actual stepfamily distributions. Many authors have cited the increase in divorce rates and the subsequent swell of stepfamilies in the general population, estimating that sometime within the span of this decade (2000-2010) stepfamilies will reach and maintain majority status indefinitely (Carmichael, Webster, & McDonald, 1997; Counts, 1992; Darden & Zimmerman, 1992; Pasley & Ihinger-Tallman, 1995; White, 1998).

The primary organization currently maintaining nearly all stepfamily data is the Stepfamily Association of America. In a statistical summary of U.S. Census Bureau data from 1988 through 1998, the Stepfamily Association of America

(2000) reported that of all first marriages 52% to 62% end in divorce. Of divorced persons, 75% remarry and more than 60% of remarriages eventually divorce, indicating the highest divorce rates ever recorded. Statistical estimates indicate that for children of divorce 76% live with just one biological parent, 10% live with the biological mother and stepfather, and only .6% live with the biological father and stepmother; whereas 10% live with other combinations of stepmothers and stepfathers. (The model of adoptive parent with stepparent combination totaled less than 3%.) The Stepfamily Association of America researchers believe that the method by which these estimates are figured omits the variable that child custody introduces as children move between homes and, thus, how parents officially claim them. The Stepfamily Association of America also reported that the U.S. Census Bureau policy, perhaps in frustration of dealing with such complexity, has discontinued providing estimates of divorce and remarriage except those available from the 1990 census. A critical aspect of these data is that cohabitating couples with stepchildren and children of divorce may be listed as single-parent homes, thus further obscuring stepfamily population estimates.

Considering the divorce and sequential remarriage rate, stepfamily numbers will never remain sufficiently stable to count them precisely. The substantial divorce and remarriage rate, which is mainly associated with the breakdown of a social institution, also represents the stepfamily as the new classic family. Yet, categorical variation occurs among stepfamily types and requires a definition of unique individual and group traits.

Unique Stepfamily Aspects

For this literature review, no studies were found that attempted stepfamily population estimates by type. However, stepfamily types vary by number of divorces, who remarried and how many times, how many children came from which marriage, and custodial plans. Such distinct types of stepfamily and divorce matter in understanding stepfamily members and particular issues as well as providing a basis of how members may form identities. If social development of and within the family unit varies significantly by type, understanding relevant distinctions is limited if all types are assumed as normative (Dawson, 1991; Gamache, 1997). For military service providers, the critical issue is that any lack of their awareness that such differences in types exist may affect treatment planning and outcome adversely. A lack of awareness by the USAF or other military branches with regard to categorization of stepfamily types and serial divorced members may be attributed in large part to how personnel statistics and note documentation are kept.

Attributions and Traits

Understanding how stepfamilies are counted is the proverbial tip of the iceberg in the range of their diverse formations. Remarriage, marriage into, or initializing a stepfamily carries automatic instability (Anderson & White, 1986; Booth & Edwards, 1992; Borrine, Handal, Brown, & Searight, 1991; Claxton, 1992; Coleman & Ganong, 1997; Combrick-Graham, 1989; Hoffman & Ledford, 1995; Hogan, 1994; Hutchinson & Hutchinson, 1979; Johnston & Campbell, 1993;

Kaslow, 1988; Kurdek & Sinclair, 1988; Lindner, Hagan, & Brown, 1992; Minton & Pasley, 1996; Pasley, 1987; Pasley, Koch, & Ihinger-Tallman, 1993). Studies from these authors and others like them point to enduring contrasts as well as similarities between traditional families and stepfamilies. These distinctions among aspects serve to form barriers to full social inclusion (Claxton-Oldfield & Butler, 1998; Phillips, 1997).

Observations of stepfamily dynamics have revealed that maladaptive group and individual behaviors present barriers to obtaining basic stepfamily members' needs and meeting general social expectations without informed professional guidance. One identified barrier pointed out that the inability of stepfamily members to optimally organize their relationships was the greatest predictor of marital instability, family conflict, legal (custodial) dilemmas, and serial divorces (Huntley, 1995). Another identified barrier was that establishing and maintaining conceptualized boundaries and roles that recognize an insider and outsider status are crucial aspects of stepfamily formation (Belovitch, 1987; Buehler, Hogan, Robinson, & Levy, 1986; Burrell, 1995; Ganong & Coleman, 1995; Kaslow, 1988, 1998; MacDonald & DeMaris, 1995; Swenson, 1997; Walker & Messinger, 1979).

Functional similarities include positive marital adjustment, strong positive biological child-parent bonds, family member inclusiveness, and couples mutually deciding beneficial family choices. Functional distinctions include diminished biological child-to-stepfather relations and biological child-to-parent coalitions.

Stepfamily dysfunction is typically represented by intensified patterns of those distinctions. This intensification occurs in remarriages that frequently experience ex spouses who persist with negative behaviors such as parent conflict and hostility from legal contentions regarding custody. Furthermore, intensification occurs in frequent accusations of being unfit, commonly yet unsubstantively alleged by family law litigation. Although some intensification facts are not yet statistically demonstrated as significant abuse predictors in divorce, other statistics have suggested that readiness to divorce is the pivotal attitude determining stepfamily cohesion. The less willing couples from previous relationships are to discuss resolution, the more frequently they divorce and remarry. Some data indicate that sequential remarriages occur not because of dissatisfaction with the institution or divisions of labor but because of disillusionment with the previous marital partner.

Stepfamily legal status defines much of their identity and indicates value attributions based on what the stepfamily form contributes to society. The social status attributed to stepfamilies stems from how stepparent roles are legally regarded (Andersen, 1998). The degree to which the biological parent's role is legally and psychologically exercised within the stepfamily dynamic determines how well child functioning and development progress (Adler-Baeder, 1999; Bray & Kelly, 1998; Keshet, 1989; Levin & Sussman, 1997; Mason, 1994; Okin, 1989; Pasley & Ihinger-Tallman, 1995). Findings indicate that when biological fathers remarry, the stepmother takes a less active position as do stepfathers with biological mothers. In the former example, it was found that fathers who were

active with their children assumed a more intimate nurturance role, whereas stepmothers assumed a more detached role marked by more (step) child-care and home-maintenance responsibilities.

The accumulation of various social and interpersonal barriers further influences how stepfamilies are legally regarded. Remarriages are often hypothesized as incomplete social institutions (Levin & Sussman, 1997; MacDonald & DeMaris, 1995). An analysis of family law codes concerning stepchild and stepparent rights indicate that, although traditional family relationships are encouraged and supported, other family forms are necessarily accorded less status and are perceived from the outset as unfit (Andersen, 1998; Tebben, 1992; Turkat, 1999; Waldron & Joanis, 1996). Legal definitions identify yet relegate stepfamilies to a subordinate class status (Bray & Kelly, 1998; Garrity & Baris, 1994; Haralambie, 1997; Huntley, 1995; Levin & Sussman, 1997; Mason, 1994; Okin, 1989; Pasley & Ihinger-Tallman, 1995).

The influence of stepparent roles and functions on social status is also visible as a predictor of gender-role distinctions. Families with values employing traditional divisions of labor result in lopsided benefits after divorce or remarriage between the father-child set and the mother-child set (Okin, 1989; Wallerstein & Kelly, 1980). Divorces occurring under those instances typically point with support from family laws toward the most vulnerable parent position: the female (Volgy, 1991). When parent gender roles are organized around male authority, the incidence of dominance, conflict, and violence to spouses and children increases.

This hierarchy is assumed to be the natural order of family relations but serves to subordinate most family members without their knowledge or prior consent (Mason, 1994; Okin, 1989).

Two other barriers articulated in stepfamily research concern the overt issue of stepfamily difference to the traditional family form. One of the two most common barriers to researching comparisons among the stepfamily population is comparison to the traditional family model (Coleman & Ganong, 1990; Dawson, 1991; Gamache, 1997). Normative theories posit that stepfamily research is not possible until traditional family model research has developed clearer definitions of general family behavior. Such theories are based on mind-sets marginalizing stepfamily study and ultimately delay research accuracy. By default, stepfamily dissimilarity to the traditional family model supports inaccurate social and professional perceptions. Another barrier is that stepfamily subtypes are not defined in the research literature but remain pooled into an overall stepfamily category.

Substance Abuse

Few substance abuse studies have examined the predictive relationships of alcohol and family conflict on young or adult children of a stepfamily. The question here is not simply if general family dysfunction predicts increased substance and alcohol use in any family type but whether or not coming from a stepfamily increases the probability of alcohol abuse later in adulthood more accurately than being from a nonstepfamily.

Wolfinger (1998) looked at parental effects on adult children's substance use and found that parental divorce increased the probabilities of smoking in men and women and problem drinking in men. However, a parent's remarriage offsets divorce effects. Although socioeconomic status also influenced the association between parental divorce and smoking, economic status was inconclusive in problem drinking. Velleman and Orford (1999) developed a path analysis showing how family dysfunction contributes. They found results only when parental problem drinking was assumed as a cause of family disharmony. Alternative models examining the reverse matched the correlation coefficients less well than the first model. Yet, their sample did not differentiate families by type. Hoffman and Johnson (1998) studied the predictive effects of family structures and adolescent drug use. Their findings indicated that when gender, age, race, family income, and mobility are controlled for, father-only and mother-stepfather families are at much greater risk of drug and alcohol use than are nondivorced or remarried parents. The family-type variation of father-stepmother doubled the risk of drug and alcohol use. Hoffman and Johnson found no predictive effects in socioeconomic status.

Robinson and Rhoden (1998) discussed correlates of alcoholism, indicating that parental divorce and disrupted families lead to higher emotional problems in families, but here, too, family type was not separated in their examination or review of previous research. They discussed more of the obvious effects on young children such as academic performance or behavior problems, but they did not

examine stepfamily dynamics in particular that contribute to or predict children's drug or alcohol abuse. Lawson and Lawson (1998) and Brown and Lewis (1999) described in great detail the etiological theories of alcoholism in families and family structures, but they also overlooked the unique dynamics within stepfamilies that may not fit the suggested models in the same ways. Their focus of family structures omits the stepfamily model and instead examines power structures between nonstepfamily parent-child dyads.

Research and Clinical Issues of Stepfamilies

Theoretical Approaches

Several theories have offered diverse explanations identifying stepfamily behaviors. Fine and colleagues (1999) offered a social constructivist multimethod approach to understanding the stepparent role. Elliott (1997) advanced theoretical contributions from structural, psychodynamic, cognitive theory, attachment theory, trauma theory, narrative theory, and feminist theory. Fine (1997) used a policy model to explain how stepfamilies are portrayed and used to influence legal reforms. Evolutionary social scientists considered that instinctual parent and adult reproductive behaviors originated from environmental adaptations (Daly & Wilson, 1998; Emlin, 1997). Each view offers insight to better understanding stepfamily dilemmas.

Other theories have tended to underestimate stepfamily dynamics in a reliance on unseen phenomenon. An application by Crosbie-Burnett (1989) of their ABCX family stress model indicated a heavy focus on members' perceptual

reactivity surrounding immediate family problems, overlooking a broader context of systems interaction. Fine and Schwebel (1991) believed that social, familial (encapsulated social norms), and individual cognitions support a cognitive stress model; that is, stepfamily members act according to how they believe they are socially expected. Yet, these types of views overlook conflict etiology in focusing on symptomatic reflections of the stepfamily.

The ecological model emphasizes a reliance on more cognitive processes integrating systems theory, stress theory, social cognitive theory, and the coercion model (Adler-Baeder, 2001).

> This integration provides a comprehensive view of the etiology of conflict and physical abuse in families. The social cognitive behavioral model focuses on individual and dyadic psychology and processes, yet is compatible with larger contextual views. Factors are presented that influence the level of stress for individuals in biological families and stepfamilies. Some of the variables and relationships among variables are supported by findings in the general child abuse literature. Other factors included are unique to stepfamilies and are supported by evidence from studies of stepfamilies and conflictual stepparent-stepchild interactions. Included are a number of extrafamilial context variables and a number of intrafamilial context variables that potentially lead to parental stress. . . . The model suggests that high stress levels combined with the socio-cognitive coercive behavior process can lead to abuse. Cognitive processes of the parent and child act as a filter through which the environmental stimuli affect parent and child behaviors. Negative cognitions result in negative behaviors that further elicit negative cognitions and result in negative behaviors from the other individual, setting a coercive process in motion toward increasing levels of conflictual interactions. (p. 26)

Family members viewed from this model have greater allowances for determining their own behavior than evolutionary frameworks offer. How much of a role self-awareness plays may be the better question emerging from all

comparisons. However, the central question remains unanswered as to whether or not stepfamily dynamics occur more as a function of psychopathology or adaptability.

Recommended Stepfamily Therapy

Stepfamilies require specialized intervention strategies respecting the tensions, legal relationships, and dynamics between members. Primary clinical recommendations are to avoid traditional family comparisons, increase marital satisfaction, support commitment of family above self, and abide by sanctioned internal and external boundaries (Bray & Kelly, 1998; Huntley, 1995; Levin & Sussman, 1997; Visher & Visher, 1996). Other recommendations reflect a critical need for the therapist to recognize the stigmatized role of the stepparent and member and to validate individuals' experiences, normalize contexts, reduce helplessness (familial and legal), respect inherent stepfamily life cycles, and respect the extended adjustment time of younger members (Bray & Kelly, 1998; Huntley, 1995; Pasley & Ihinger-Tallman, 1995). The most successful stepfamily interventions advocate a course of frequent recurrent therapy from early development to family maturity.

Stepfamily relationships are extremely fluid systems. Stepfamilies face challenges of incremental group stability and systematic setback. Accordingly, their ability to comprehend and cope under nontraditional circumstances without informed social support routinely becomes overstressed. Traditional family therapies and interventions may only address surface aspects of deeper issues

(Papernow, 1995; Pasley & Ihinger-Tallman, 1995). Even when stepfamily members display positive stable interactions with each other, the nature of those relationship dynamics is always subject to spontaneous interpersonal renegotiation. This renegotiation process seemingly supersedes developmental processes, especially in stepfamilies.

USAF Stepfamily Population

Although it is unnecessary to pinpoint when the stepfamily population may outnumber nonstepfamilies, knowing stressors that stepfamilies face will reveal circumstances influencing how often stepfamily restructure occurs. Even with only estimates of rising stepfamily numbers, statistical predictions indicate a sizeable population of stepfamily and divorced persons in organizations with policies formed around a traditional family type. Furthermore, poorly understood infrastructural change in any organization's membership results in misassumptions of needs and services rather than accurate estimates (Bolman & Deal, 1997; Pfeffer, 1997; Scott, 1998). For national defense branches like the USAF, knowing how to better support the people doing the work is vital to mission goals. Knowledge from the present investigation will assist in planning services and resources to meet specific USAF stepfamily needs effectively.

Although stepfamily research estimates generalize that stepfamilies outnumber traditional families in the USAF, the current lack of military research on specific stepfamily types indicates a critical absence of knowledge (F. Adler-Baeder, personal communication, June 20, 2000; J. Bray, personal communication,

May 31, 2000; J. Giles-Sims, personal communication, June 14, 2000; F. Kaslow, personal communication, May 31, 2000; K. Pasley, personal communication, June 2, 2000; J. Pittman, personal communication, June 16, 2000). No direct recording method exists in the military branches' personnel systems regarding demographics of remarriages, serial divorce, or stepfamily status. Consequently, an awareness of USAF executives' knowledge about family types of active-duty members in the organization and how well the USAF is equipped to service those stepfamily or divorced members' needs is not specified.

That gap in knowledge also extends to how stepfamily research information is understood and promoted by USAF service planners. A review of the military branches' technological reliance disseminating nonspecified family psychoeducational literature found how the pattern is reinforced. With the emphasis on traditional families only, stepfamily research lags behind that of the traditional family model. Determining specific consumer information support for stepfamily members is critical now and will become even more so. Assuming that the current USAF downsizing trend continues and that stepfamilies are now the majority, there is an even greater need to have better information available. Stepfamily information must be more reliable and more easily obtained among USAF stepfamily members.

USAF Stepfamily Stressors, Reactions, and Effects

Family studies originating from the USAF research community have passively and actively elected not to examine stepfamily abuse issues separately from families in general (Black, 1993; Daley, 1999; Einstein, 1982; Hunter, 1982;

Hunter & Nice, 1978; Kaslow, 1993; Kaslow & Ridenour, 1984; Pittman, Bartoszuk, & Wall, 1999; Pittman, Bartoszuk, & Lee, 2000; Pittman, Bartoszuk, & Taylor, 2000; Pittman, Lee, & Pate, 1999; Pittman, Teng, & Knighton, 1998). A possible bias within widespread family studies is that as research on the traditional family progresses needs for stepfamily-specific studies are easily generalizable. This possibility reflects the underlying faults emphasized in broad family research that comparisons to traditional families and assumptions of those data similar to stepfamily types are sufficiently complete. However, ignoring such subtle distinctions may equivocate the commencement of such studies, suspending research of the contemporary stepfamily experience. However, while research of the general USAF family continues, the USAF population with stepfamily and divorce conditions remains undescribed, and many characteristics remain unknown.

Relevant findings of stepfamily research indicate that typical family stressors are intensified and compounded in stepfamily contexts. Adler and colleagues (1998) found that predictive factors of marital dissatisfaction, low connection to outside activities and social groups, and high personal stress were higher in stepfamily conflict and more often resulted in abusive family outcomes. However, those same predictors are characteristic of daily family military life and are more typical in base housing communities (Kaslow, 1993; Kaslow & Ridenour, 1984). The overriding issue raised by researchers in this field calls for determining what factors are associated with the etiology of severe distress in stepfamilies in addition to uncovering elements in conflicted stepparent and stepchild interactions.

If military family researchers indicate this pattern among typical USAF families, the implications for stepfamilies likely indicate an even less positive outcome for relationships in stepfamilies.

Adler and colleagues (1998) conducted a USAF study concerning physical child abuse by military fathers and the differences between biological parenting and stepparenting. They found significant differences in the variables of the victims' ages and genders, whereas the offenders' ages, discipline beliefs, and rigidity and control in the family were the most noticeable variables. The authors concluded that military stepfamilies experience higher levels of intrafamilial stress due to rigid parenting and parenting belief systems than the intact military family. Yet, a social context explaining why such behaviors seem characteristic was not given.

Utilization, Barriers, and Pilot Studies

When the areas of stepfamily research, therapeutic practice, incidence and factors of substance or family abuse, and military community are combined into an integrated topic of study, the results indicated that this composite is largely undeveloped. Several prominent researchers of military families, abuse issues, and stepfamilies reported that little to no research currently exists about this particular research blend in the military and USAF or studies of stepfamilies in general (F. Adler-Baeder, personal communication, June 20, 2000; J. Bray, personal communication, May 31, 2000; J. Giles-Sims, personal communication, June 14, 2000; F. Kaslow, personal communication, May 31, 2000; K. Pasley, personal communication, June 2, 2000; J. Pittman, personal communication, June 16,

2000).

Stone (1998) studied USAF members' attitudes and perceived barriers in utilizing base services. Using an instrument called the Military Survey of Attitudes Towards Services (MATS), Stone identified several perceptions that active-duty and family members encountered as obstacles to seeking services or in which to participate. The most common barriers were negative career impact, lack of confidentiality, insufficient provider skills, help-seeking stigma, and lack of available services. He concluded that the USAF system discourages members from seeking help even when services are offered. As indicated in his data analysis, the two main characteristics that most often prevented members from seeking help were embarrassment and personal weakness. However, Stone's study sample was not sorted by whether individuals or families lived in stepfamily circumstances. Neither did Stone assess the degree to which the participants actively sought to avoid voluntary or mandatory services as a result of their family legal orientation. Stepfamily and divorced members may feel more embarrassment and personal weakness more often than do members with nonstepfamily or no-divorce conditions.

Studies such as Stone's (1998) are important and contribute to better clinical designs for the USAF population. In my opinion as a USAF practitioner surveying USAF and civilian field leaders, clinical treatment in the military setting most likely fails to accurately meet the needs of stepfamily and divorced members, almost entirely falling short of recognizing specific stepfamily therapeutic

recommendations. USAF clinical practice must go further in ensuring that quality care is available for the work force. If such interventions are currently used in clinical settings, I believe the most likely reasons would be an exception to the standard of practice rather than from official medical recommendations. Thus, the overall lack of preventive attention in this branch of practice puts both the stepfamily and traditional military family at risk. For example, nonstepfamilies also have a high probability of divorce and remarriage, thus evolving into a stepfamily climate where services with knowledgeable providers are unavailable.

A descriptive pilot study was conducted to examine clinical record files of 559 patients identified with stepfamily conditions (Miller, 2000a). The pilot study sought to identify, define, and determine characteristics and correlates in three main clinical practice areas in a representative sample of USAF stepfamilies: (a) substance abuse, (b) family violence, and (c) mental health counseling. The characteristics of the adults' divorces, remarriages, and abuse histories provided the strongest links to previous stepfamily research. First, preliminary findings from substance-abuse programs showed unexpectedly higher numbers of patients with stepfamily and divorce conditions, whereas there was a smaller proportion of patients with stepfamily and divorce conditions in the family violence clinic and mental health clinics. For example, in the substance abuse clinic, more than two thirds of the patients had a previous or current stepfamily and divorce situation.

The general stepfamily research literature fails to address the proportion of stepfamilies needing clinical or alcohol abuse treatment services. Substance abuse

and family violence are associated with family dysfunction, but the stepfamily member proportion in treatment in the family violence clinic was only one fourth of its annual caseload. Conversely, stepfamily research literature predicts the highest rates of abuse and service needs in stepfamilies. Thus, it is unknown why USAF members with stepfamily conditions and substance abuse problems are referred for clinical services at a higher rate than are those with symptoms of family violence.

When looking at the relationship between stepfamily history and predictor variables of stepfamily conditions among active-duty members and their spouses, the majority of cases indicated patterns of developmental experiences in childhood, adolescence, or young adulthood. Based on social learning theory, a tentative hypothesis could be that early exposure to family conflict resulting in separation, remarriage, and subsequent divorces likely may influence such behaviors in later relationships or families. Are stepfamily members then predisposed to repeat their parents' actions? As a tentative answer, most active-duty members had histories (at the time of the incident) of their own divorces and remarriages or parents with divorces and remarriages.

In another pilot study (Miller, 2000b), four nonactive-duty female spouses were selected for a qualitative study examining their experiences as wives with biological children or stepchildren in families with low or high stress. Two women reported relatively low stress with legal (and therefore financial) requirements because the children's biological fathers had relinquished paternal rights very early

in their lives. The two remaining women reported isolation, lack of information of resources, deprivation of necessities due to forced litigation by the children's father, and symptoms of chronic depression. Of those two women, substance abuse was a factor in the breakups of their first or previous relationships and for one woman was a current cause of poor marital quality. Although all admitted past physically or emotionally abusive relationships, none spoke of experiencing current family violence. Yet, all spoke at length regarding frequent antagonism with ex spouses and current spouses in how to conduct family logistics and how each member felt emotionally about his or her stepfamily.

Summary

Knowledge of stepfamily and divorce issues is complex. Problems continue with counting numbers because of the types of diverse stepfamily structures. Unique stepfamily attributes appear to result from members' dysfunction, social barriers, and psychological problems. When researching members' alcohol abuse, studies have not developed an integrated or comprehensive focus into contributing factors within stepfamily and divorced persons' contexts. Stepfamily research issues are diverse, yet disagree on how to explain stepfamily dynamics as psychologically, interpersonally, or socially oriented. Stepfamily therapy recommends nontraditionally based interventions that respect specific processes of each stepfamily member. The USAF population is likely as affected as the general population. Literature reviews indicate a critical lack of awareness of stepfamily divorce issues in organizational structure, clinical services, and mission impact.

For this study, the overall question considers whether or not a function of family composition is the impact of externally imposed (social and legal) limitations to stepfamily identity development. Some stepfamily members' occupations and familial stress-coping strategies such as increased alcohol use may be an indication of the person's loss of perceived power about his or her career development and family cohesion, which could precipitate a behavior pattern of serial divorce and remarriage.

CHAPTER 3

METHODOLOGY

The methodology of this dissertation is explained in this chapter. Methodology discussion includes research design, operational definitions, sampling procedures, data collection procedures, instrumentation, and data analysis.

Research Design

Since an absence of basic knowledge about the impact of stepfamily and divorce conditions on the USAF population was demonstrated in Chapter 2, research of this area must begin at a fundamental level. Accordingly, this research design is exploratory and descriptive. This research has the potential to expand into subsequent studies and as such to establish descriptive statistical methods to manage these data sets, which is not only necessary but is also critical to the descriptive process (Glass & Hopkins, 1996).

Many studies of help-seeking behaviors have been predominantly descriptive (Fischer & Farina, 1995; Harlow & Cantor, 1995; Horowitz, 1997; Johnson, 1988; Kelly & Achter, 1995; Veroff, Kulka, & Duvan, 1981). Two components of help-seeking behavior identified in such studies were external (social, institutional) barriers and internal (psychological, ideological) attitudes. This study employed these concepts to examine the basic similarities and differences in the study

population.

The study design used three methods of data collection: (a) a record review of outpatient substance abuse program clinical files, (b) a survey of members currently attending an outpatient substance abuse program with a new instrument, and (c) an interview with qualified members currently receiving services in an outpatient substance abuse program. Record review data were taken from three USAF clinical sites, whereas only the MATS survey and focus group interviews came from only one clinical site. Since the scope of the design was not exhaustive or experimental, the rationale for using one base to collect survey and interview data was believed to be an adequate representation if no significant base differences were found.

Operational Definitions

As a reminder, USAF members with alcohol-related problems were studied in this research project. Marital status data alone could not identify whether any member met study criteria. The primary study criterion is a discrete variable that was divided into two categories: (a) stepfamily and divorce conditions and (b) nonstepfamily and no-divorce conditions. This variable assessed data from the variables marital status and parental divorce and remarriage history. These variables qualified whether or not members of treatment met study criteria and into which group their data were placed for analysis. Separating the numbers of stepfamily and divorce members' files from those without stepfamily and divorce conditions created a rate that identified for the first time the magnitude of service

provision for members with these circumstances. Based on this operational definition, again, the research questions are:

1. How many members with stepfamily and divorce conditions were treated for alcohol incidents in three USAF substance abuse programs during 2000?

2. What were the demographic, career, and clinical characteristics of the members with and without stepfamily and divorce conditions in the three substance abuse programs?

3. Did USAF members with stepfamily and divorce conditions who received outpatient substance abuse program services have equivalent characteristics to the general USAF population?

4. What were the similarities and differences between members with and without stepfamily and divorce conditions from outpatient alcohol treatment in substance abuse program services?

5. What were the attitudes and beliefs of USAF members with and without stepfamily and divorce conditions that indicated barriers to treatment in an outpatient substance abuse program?

Research Question 1

Answering Research Question 1 required obtaining information sources that contained historical and current data of members with the necessary marital, family, and treatment conditions. The number of members with stepfamily and divorce conditions who received treatment was determined not by how many appointments members had but how many discrete cases per member were initiated

in one calendar year of a clinic's caseload. As members were referred for services, case files per each member were established. If members had subsequent incidents, each incident was included into the member's same outpatient file; thus, only a member's discrete record was counted, not the number of referrals for services he or she may have received.

Although the specific number of incidents and appointments per patient was not used in determining how many members were to be studied, these two variables were included as two of the five variables under part three of Research Question 2. The members' other characteristics were found through reading their outpatient substance abuse program clinical files.

Research Question 2

Research Question 2 examined the characteristics of USAF treatment members with histories of stepfamily and divorce conditions. Answers to Research Question 2 were obtained through a record review in three areas of the members with stepfamily and divorce conditions who were outpatients in a substance abuse program. These areas were: (a) demographic, (b) career, and (c) clinical. The demographic variables included age, gender, residence location, children in home, and marital status. The career variables were rank, duty, time in service, time on station, and duty determination at end of treatment. Clinical variables were the number of clinical appointments kept, suicidal history, parental history of stepfamily and divorce, history of abuse as victim and offender, number and type of alcohol referral, and diagnosis. The collection sheet listing these variables is

found in Appendix A.

Research Question 3

Research Question 3 examined the equivalency of characteristics from the members sampled with similar data of USAF personnel across relevant organizational divisions. An examination of equivalency provided an understanding of where the members with these conditions were distributed within the hierarchical structure from the broadest level of the USAF through smaller functional branches and eventually to the specific clinical treatment area. Determining their organizational position was believed to help identify characteristics that could describe sample homogeneity and, thus, increase generalizability.

There was one drawback in gathering data for Research Question 3. Comparing the equivalency was not possible between the number of members meeting study criterion and each specific USAF organizational level. This inability occurred because USAF personnel offices do not collect statistics about each member's number of divorces, remarriages, and stepfamily status (D. Robinett, personal communication, November 17, 2000).

Research Question 4

Research Question 4 examined the differences between the characteristics of USAF outpatient treatment members with histories of stepfamily and divorce conditions from USAF members without those conditions. In order to answer this

research question, the stepfamily and divorce conditions variable was compared across the demographic, career, and clinical characteristics of both types of USAF members.

Research Question 5

Research Question 5 sought to increase an awareness and understanding of the attitudes and meanings of both types of members in treatment. This question specifically addressed what perceptions and beliefs they attached to their experiences in the USAF as related to their individual and interpersonal development in career and family. A survey instrument and group interviews were used to answer Research Question 5.

In order to examine what barriers USAF members hold toward accessing services, the MATS survey was provided to members for completion on a voluntary basis. Their scores on attitudes toward seeking mental health services in the USAF provided evidence that indicated what attitudes they held about seeking help in substance abuse clinics after their referral. However, since the respondents were in treatment within the outpatient substance abuse program and nearly all referrals are mandatory and automatic, these data cannot be conclusive. The goal of this research question assessed whether or not the MATS congruently reflected the expressed attitudes of the members.

In order to more completely document the beliefs held by the alcohol treatment group, the following subresearch questions were prepared for members both with and without the stepfamily and divorce conditions: (a) What do you see

as barriers to USAF substance abuse clinic services? (b) How much easier or more difficult do you believe such services are to accept because of being part of a stepfamily (nonstepfamily)? (c) How can these services be improved to better meet your needs as a stepfamily (nonstepfamily)? These subquestions assisted in understanding members' expressed beliefs about their own stepfamily and divorce experiences. Members with nonstepfamily and no-divorce conditions were also recorded in order to examine where comparisons differed from other members' characteristics. Such responses specified members' personal views, but they also generalized or actively spoke for others like themselves whom the members knew both professionally and socially. These data addressed members' beliefs within occupational and family themes that may have led toward their referral incidents of excessive alcohol use.

Sampling Procedures

A purposive sample of 330 USAF members selected from three air force bases comprised the research participants. Sample data came from outpatient substance abuse clinical records permanently filed in the clinic storage bins under calendar year 2000 at three substance abuse clinics at USAF bases in the Rocky Mountain and Pacific regions of the western United States. Each of these three bases had different missions: (a) Air Mobility, (b) Air Combat Command, and (c) Air Force Material Command.

The clinical directors of each Life Skills Support Center of the medical groups at each air force base were notified of the request to conduct research at

their clinic, briefed of the research proposal, and asked for their permission (see Appendix B). Clinic files were used whether or not the patient was released from or completed the substance abuse program. The regional institutional review board for the USAF located at the David Grant Medical Center of Travis Air Force Base, California, provided approval to conduct research within the specified clinics. In this study, there were three types of data: (a) record review, (b) MATS instrument, and (c) focus group.

The record review process initially identified 374 active cases permanently filed in the substance abuse program storage bins for calendar year 2000, which were referrals stemming from incidents involving alcohol use by military members. The records examined were currently not being used for any member's treatment. The records were closed cases of members who may or may not have still been assigned to the base. The records were scheduled for permanent warehousing in accordance with USAF instructions that specify a 2-year maximum length of time that records may remain in storage within a clinic after case closure.

The MATS survey was provided to members from one clinical site only in an exploratory fashion. Completed surveys were received from 26 outpatient substance abuse group members. Of the surveys returned, 24 met participant inclusion criteria and 2 surveys met exclusion criteria.

There were originally 10 focus group participants who volunteered to respond to the qualitative research question. Two members declined participation during the process of completing informed consent documentation paperwork,

which was required by both the University of Utah and USAF Institutional Review Boards. Of the 8 participants, there were 5 members who participated in the stepfamily and divorce conditions group, and there were 3 members who were in the nonstepfamily and no-divorce conditions group. These members were part of the substance abuse treatment group. They had completed the MATS prior to their respective focus group session; consequently, they were not counted again for the sample's total.

Through an examination of the data from the records review, the research intended to determine whether or not the characteristics accurately represented the larger population and the members who completed the MATS as well as the members who provided focus-group responses. The quantitative analyses of the characteristics determined from clinical file information provided the basis of actuality from which the qualitative realities of members' responses were later described. Thus, a primary research goal addressed how well characteristic variables from the records review file group related to the survey and focus groups' data across and among broader hierarchical divisions of the USAF.

The broadest level examined statistical information about personnel from the USAF member population. Although there are different organizational divisions below the USAF level, many of those levels have diverse functional levels of executing daily air-base operations. The Major Command level provided a meaningful focal point because the functional mission performed by the members assigned to it determines the organizational nature of all air force bases. Important

to this study was whether or not air force bases were similar in personnel composition.

There are nine USAF Major Commands that define much of the geographical and USAF base distribution. The sample was obtained in the western United States, specifically the Rocky Mountain and Pacific Coast regions where there are 22 active USAF federal installations. Of the various types of other Major Commands in the region, there are 3 Air Mobility Command bases, 5 Air Combat Command bases, and 4 Material Command bases. Three USAF bases were used for collection. Each base represents a separate mission within the USAF. When combined in a sample, each base would provide some indication if the target group would retain stable characteristics across missions.

The Major Command, known as the Air Mobility Command, is responsible for mass transportation of personnel and equipment to and from combat and peacetime operations. The Air Combat Command is the most operationally active command of the three because of the responsibility of carrying out strategic and tactical training and real-world combat operations. Air Combat Command members perform various jobs to keep different fighter aircraft and weapons systems functioning. The USAF Material Command is a weapons management organization.

The next functional level is at the site level or air force base. These bases vary in number from one to the other, but each base is oriented to contribute one type of defense (war or peacetime) coinciding with the mission of the parent

command. Base sizes are roughly equivalent to each other in the proportion of personnel and equipment, with some bases being very large and other bases being quite small. Overall, most USAF bases of the sample were similar to each other in facilities, equipment, and personnel. The next level examined was the sample at the base level. Within the sample are three subsamples: (a) the record review, (b) the survey group, and (c) the focus group. In order to determine overall sample characteristics, the three parts were combined into this separate base level. Finally, in order to determine whether or not the record review characteristics represent the survey and focus group sample, a separate review within each of these categories was attempted.

Data Collection Procedures

The data for this study were obtained from medical records of the 3 substance abuse clinics, from surveys, and from focus groups. The study data were also obtained from 26 volunteers who were outpatients in a substance abuse program. Secondary data were obtained from the USAF Personnel Center database, which allowed for general equivalency comparisons. These data allowed for descriptions of general equivalency between the sample and the USAF population. These data were obtained at the on-line public Web site by entering requests for the specified year and variable characteristics. Some variable characteristics needed for the study were not available on-line.

The first step in the patient record data collection required a determination of the number and location of the substance abuse program outpatient records from

the calendar year 2000. The data collection protocols were used to record the study variables found in the records. Once the total number of files was determined, the Life Skills Support Center staff was briefed regarding how the files were to be used. A section of the Life Skills Support Center was set aside for the private review of files. The clinical director or designee was responsible for ensuring that all data collection sheets were stored in the patient file bins at the end of each data collection day. The patients' social security numbers were not recorded on any of the protocols. If a patient file number was listed on the file, that number was entered above the column of the data protocol. If no file number was available, patient names were used. Approximately 90 records per day were reviewed, and all record review data were collected within a 2-week period. At the end of data collection, all names and file numbers were removed from the protocol sheets. Three hundred seventy-four files were reviewed, with 306 files declared eligible for this study.

The second step in data collection required using the MATS survey as well as using interviews of regularly scheduled treatment group members assembled at one clinic location. The members were approached prior to the start of their regularly scheduled weekly group therapy sessions. The survey process began by asking all alcohol treatment group members to participate in the study. Members who agreed to participate were presented with the study criteria (having a past or current history of the study conditions—nonstepfamily and no-divorce or stepfamily and divorce). A brief explanation of the study was given while a participant

solicitation memorandum was passed around the room (see Appendix C). A question period followed in which members asked for clarification. Those who chose to complete the surveys were given adequate time and space in which to read and answer the questions without being disturbed. Surveys were collected immediately upon completion and placed in a manila envelope. Names or personal identification were omitted from the surveys. However, information regarding their status in relation to the research criteria was requested and annotated at the top right-hand side of the instrument. Nearly all of the treatment group volunteered to complete the instruments.

As with Stone's (1998) sample of attitudes and barriers to helping services, participants in the present study also made several written responses. Those comments were analyzed in accordance with qualitative procedures used for the focus group data. Themes and patterns were described, classified, and interpreted consistent with recommendations from Creswell (1998) and Strauss and Corbin (1998).

The next step in gathering data of members' attitudes toward service barriers was the focus group selection process. This process began by asking the assembled group members if each were willing for their views on the research question to be recorded while in a focus group format. Participation was voluntary, and again, no names or personal identifiers were desired. Those who agreed to participate were again presented the study criteria to ensure that they would be part of the appropriate group (nonstepfamily and no-divorce conditions or stepfamily

and divorce conditions). After determining who would qualify for either group, the participants were told where the group would be held. While one group was being held, the other participants were involved in their regular group. Groups were switched when the regularly scheduled break time of their treatment group occurred.

When group members were assembled in the room, the participants were briefed about the nature of the focus group. Ground rules were presented so that each participant respected others' opinions and were familiar with the process of asking the questions and recording the answers. Audiotaping began after all participants agreed to those conditions. Efforts were made to arrange participants into groups of no more than six to eight members each. Permission from patients was obtained at the beginning of each focus group and was documented on USAF informed consent documents. Two audiotape machines were used and tested prior to the session. A guided discussion in a structured script was prepared for each focus group and was audiorecorded simultaneously for later transcription. Three specific focus group questions and several prompting questions were prepared to facilitate the discussion and loosely direct the focus of the participants. The questions were presented for discussion and addressed during further conversation. Discussion was brought to a close. The participants were reminded that professional guidance was available if needed. Each group meeting lasted between 60 and 90 minutes. Again, these data were collected at only one substance abuse clinic.

Instrumentation

Record Review

A protocol data collection sheet guided the record review of the 306 substance abuse clients. That collection instrument was comprised of three sections, which were designed to gather discrete information on members' demographic, career, and clinical variables (see Appendix A).

MATS Instrument

The MATS survey was used to record members' views of service barriers compared with the study sample. The original MATS sample was more randomized and met statistical tests of homogeneity, although the participants were self-selected. The purpose of the MATS in this study may indicate, though not conclusively, whether or not greater barrier scores were present between the members with the two study conditions: (a) stepfamily and divorce members and (b) nonstepfamily and no-divorce members.

The MATS (Stone, 1998) is based and validated upon the Attitudes Toward Seeking Professional Psychological Help Inventory (ATSPPHI) (Fischer & Farina, 1995). The ATSPPHI was the basis for the MATS, which was modified in order to survey the military population. Although the instrument was not modified further for specific strata of the population in this study, some elements should be pointed out that have a bearing on the stepfamily organization. Basically, the ATSPPHI is identical to the MATS, with the primary difference being that the terms "military" and "USAF" were interchanged at points of the questions that generally addressed

respondents specifying the conditions of help-seeking behavior for the respondents. The MATS is presented in Appendix D for review. The statistics from the ATSPPHI of Stone's study were: $N = 391$, $\overline{X} = 25.1$, $SD = 5.7$, range = 29, skewness = .63, and kurtosis = -1.24. Empty responses were scored as neutral values of 2.5 midway between the four Likert points of 1, 2, 3, and 4.

The MATS instrument has four sections that categorize the respondents' scores into (a) help-seeking attitude value, (b) barrier values (two sections), (c) helping service quantity and quality value, and (d) degree of helping utilization value. The value is the ATSPPHI, which indicates a more favorable attitude towards help-seeking as the respondent's score increases and a less favorable attitude as the score decreases. This value was computed from 6 to 16. The premise of this value presents a baseline of whether or not members' opinions indicate some level of predisposition towards or necessarily have a negative view of help-seeking behavior.

An analysis of the MATS survey first examines the degree of similarity in the sample across the four categories of help-seeking values. The second part of the MATS instrument examines the four categories of help-seeking values related to the study criterion variable. The first examination assists in determining the interrelatedness of the ATSPPHI value, both discrete barrier values, the primary responsibility value, and the utilization value. This knowledge improves the ability to detect whether or not significant differences exist and where the survey indicates if any differences are located. The analysis of interrelatedness provides the baseline

by which to compare the attitudes and perceptions of barriers toward help-seeking among the members with or without stepfamily and divorce conditions.

Stone's (1998) comparison group was based on student responses from an introductory psychology class. His sample, although randomized, was mostly comprised of officers, married members, and males. Stone found that young airmen were significantly less inclined to seek services than were their civilian counterparts. Such differences between each of the studies may decrease the confidence to draw accurate comparisons. In order to draw validity from the survey, Stone further operationally defined the term "barriers" into possible impediments to access mental health services. Having defined barriers, a way of translating that meaning into measurable items was developed into two computations: (a) fear of negative career impact and (b) helping source.

The first barrier assesses the degree of the members' opinions of negative career impact through five questions rating (a) cause of harm, (b) assurance of confidentiality, (c) helping skills, (d) embarrassment, and (e) weakness. This barrier focuses more on how much members' thoughts and feelings contribute to their own fear of negative career impact. This barrier extends from the member towards the helping sources.

Thus, the first computation focused on determining internal elements of fear to career levels, and the second computation focused on the external element of a helping source as a way to explain and measure the concept of barriers. The ordinal nature of the data did not invoke statistical requirements of normalcy

because nonparametric tests were used. A high score meant that respondents agreed that the factors represented barriers.

The second barrier assessed the degree of impact that each source or type of helper had on the respondents' opinions of negative career impact among five sources (chaplains, mental health providers, commanders, physicians, and friends) and whether one may have contributed more or less to members' views of negative career impact. This barrier extends from the helping sources towards the member.

The quantity and quality of mental health services were rated across two questions. These questions refocused the respondents' opinions beyond the sources or their views of negative career impact directly onto the primary service structure responsible (or office of primary responsibility) for treatment. This value assisted in renewing and comparing members' estimations of favorable attitudes toward help-seeking. Similarities or disparities of the respondents' scores with ATSPPHI and quantity and quality values indicated the level of their own experiences with mental health services.

The final section assessing help-seeking attitudes increases the focus on members' direct levels of involvement in mental health services. Scores could be conceived as hypothetically rated unless an assessment was made that provided some indication of the nature of their knowledge about services. This value established that the respondent actually had services, seriously considered having services, or chose to have services not connected with the USAF. That assessment created a direct link to the ATSPPHI, both barriers, and the office of primary

responsibility helping service.

The design of the present study did not call for scientific comparisons and contrasts of findings with Stone's (1998) data because the selection methods and groups sampled made them categorically different. Stone's sample was more formally randomized than this study. Overall, Stone concluded that his study was sufficient to draw generalizable estimates. However, it was important for increasing generalizability in the present study to allow for discussion of the instrument's similarities and differences to describe more fully the present sample through discussion to the most similar study available. Finally, just as sample homogeneity is important to statistical significance, quantitative analysis is incomplete without also hearing what participants say about their views of the services arranged around them.

The data for the second part of Research Question 5 were interpreted by a postmodern worldview based on the philosophical assumption of the ontological framework and commensurately within the tradition of an ideational ethnography (Creswell, 1998; Kvale, 1996). Participants' meanings were described in their social setting; analyzed for themes and patterned regularities; interpreted by me as an insider component of their setting; and punctuated with narratives, tables, and figures that further describe the sample (Strauss & Corbin, 1998). Data from these sources indicated a collective ideological view marking previously unidentified behaviors but also supporting the unique stepfamily treatment needs identified in the literature by stepfamily research therapists. The method by which these data

were obtained was the focus group interview. Although group interaction reduced the control of conversation, thus allowing intermingled voices, the interaction permitted spontaneous and emotional statements stemming from other group members' comments and provided a richer detail of the data (Kvale, 1996). The focus group technique offered reliable and thick insight to the participants' beliefs (Barbour & Kitzinger, 1999; Edmunds, 1999; Fern, 2001; Krueger, 1994, 1998; Morgan, 1993; Stewart & Shamadanasi, 1990).

Data Analysis

The sample data from the records review and the surveys were entered into a statistical analysis program: *SPSS® Base 10.0* (SPSS® Inc., 1999). All focus group interview data were analyzed separately and manually in accordance with qualitative analysis. The numbers of stepfamily and divorced members in treatment for 1 year were examined first, and then characteristics of the two types of members at each data collection site were tabulated. Comparisons between the sample members and USAF personnel were examined, differences between the two types of members in treatment from the combined sites were compared, and comparisons within the record review sample and the MATS survey sample were examined. The members' characteristics were not ordinal or ratio type data. All variables were coded nominally to reflect specific categories within each variable.

Descriptive statistical measures of distributions within the samples were shown in *SPSS® Base 10.0* (SPSS® Inc., 1999) graphs of frequencies, percentages, cumulative percentages, means, medians, and standard deviations. The data for the

first part of Research Question 5 were analyzed by using the *SPSS® Base 10.0* statistical analysis program. Nonparametric analyses were used to explore the distributions and medians between the groups from the three specified sites reflecting stepfamily and divorced members in substance abuse treatment.

CHAPTER 4

RESULTS

The results of this study are presented in this chapter. Each of the five research questions is addressed. First, the overall qualification of members with the study conditions and an explanation of how cases were determined are explained. Second, a basic description of the sample members' demographic, career, and clinical characteristics is given. Next, equivalencies of those characteristics generally found across the USAF and in the sample are compared. Fourth, similarities and differences of the characteristics found in the sample across the study criterion variable are examined. Finally, members' responses to the MATS survey questions and focus group interviews about barriers to services are analyzed.

Research Question 1

How many members with stepfamily and divorce conditions were treated for alcohol incidents in three USAF substance abuse programs during 2000? There were more members with stepfamily and divorce conditions treated in selected USAF substance abuse programs than members without those relationship conditions. At each air force base, members with these conditions comprised two thirds of the outpatient population referred for treatment. The numbers of such

members were similar at all three sites. Table 1 contains the frequencies and percentages of members having the study conditions. The total (N = 297) number of members represents 9 fewer cases than were found overall among outpatient records reviewed from all sites combined (see Table 2). The 9 cases contained missing data about whether or not the person met criteria in either family type; thus, these were not included.

Case Criteria

Research Question 1 determined whether or not the discrete cases, as represented by the outpatient files reviewed, actually met criteria for inclusion in the study. Inclusion and exclusion criteria established the research boundaries of the USAF member population with stepfamily and divorce conditions through what is generally obtainable from typical patient clinical files. The inclusion criterion was "USAF active-duty member," meaning a member under a federal contract to perform designated duties full time in the USAF. Service contract criteria addressed the level of involvement in members' experiences in on-going USAF operations and culture. Facets of nonfederal or state military service such as the National Guard or Armed Forces Reserve may approximate but not fully impact members to the extent found in continuous and regulated daily routines at various and diverse geographic regions as a function of their active federal service. Out of the 374 records reviewed, 306 (82%) cases met inclusion criteria.

Exclusion criteria defined conditions concerning either outpatient file content or members' service contract. The exclusion criterion addressing service

Table 1

Stepfamily and Divorced Members by Site in Calendar Year 2000

Type	Site 1 AMC		Site 2 ACC		Site 3 AFMC		Total	
	n	%	*n*	%	*n*	%	*N*	%
Stepfamily/ divorce	65	58	54	59	65	70	184	62
Nonstepfamily divorce	47	42	38	41	28	30	113	38
Total	112	100	92	100	93	100	297	100

Note. AMC = Air Mobility Command mission, ACC = Air Combat Command mission, and AFMC = Air Force Material Command mission.

Table 2

Number of Members' Outpatient Substance Abuse Clinical Records by Site in Calendar Year 2000

Records	Site 1 AMC		Site 2 ACC		Site 3 AFMC		Total	
	n	%	*n*	%	*n*	%	*N*	%
Criteria met	115	70	96	93	95	90	306	82
Criteria not met	50	30	7	7	11	10	68	18
Reviewed	165	100	103	100	106	100	374	100

Note. AMC = Air Mobility Command mission, ACC = Air Combat Command mission, and AFMC = Air Force Material Command mission.

contract was "not active duty," meaning that the member is a family member (spouse or child) or retired from military service. Fifteen (4%) cases met this criterion. Another criterion addressing service contract exclusion was "not USAF," meaning that the member is of a branch of service other than the USAF such as marines, coast guard, army, or even cadet and candidate status. This criterion also means that the member is either enlisted within the military branches of the national guard or reserve but not as engaged in the typical duty requirements as members in active federal service. Examples typical of active-duty service are mandatory changes of station (moving to a new assignment) or deployment (assigned to a real or simulated combat environment). Twenty-eight (7%) cases met this criterion.

An exclusion criterion addressing file content was "insufficient data," meaning that within the outpatient substance abuse program clinical file either the patient did not provide enough data at his or her time of intake or the clinical staff did not have enough contact with or could not obtain enough information from the patient prior to his or her departure from the program or the USAF. Eight (2%) cases met this criterion. Finally, "not an alcohol case" means that the patient's referral incident was initiated by his or her use of an illegal substance or unauthorized narcotic substance other than alcohol alone. Seventeen (5%) cases met this criterion.

Of the 374 records reviewed, 306 were useable for the study. The total numbers at each site are listed in Table 2. Site 1 contained most of the proportional

variance within the categories of "active-duty member" and "not USAF." Sites 2 and 3 were nearly equal in percentage. Overall, the three sites were fairly equivalent across totals and criteria.

The geographical location of Site 1 compared to Sites 2 and 3 may account for the differences. Site 1 serves a region as a federal installation where diverse members such as coast guard, air force guard or reserve, navy, marines, and army active-duty members of the entire military system may seek or obtain referral services. Conversely, Sites 2 and 3 were less diverse in such a military population cross-section, less diverse in regional ethnic culture, and offered less access from other larger metropolitan cities because of geographic distance. Thus, in Sites 2 and 3, fewer cases met exclusion criteria.

Primary and Subgroups

Another focus of the examination was of the two subpopulations ("nonstepfamily-no divorce or stepfamily-divorce conditions") that emerged from the primary variable in the study. The impact of stepfamily or divorce conditions on USAF members could come not only from stepparenting responsibilities but also from their families of origin. Some of these data were missing from the total cases reviewed, but of the 298 cases having the necessary information, there were 189 (62%) members with stepfamily and divorce conditions within themselves, their parents, or both. The distribution of members with and without stepfamily or divorce conditions for each area of the data collection is presented in Table 3.

Table 3

Number of Stepfamily and Nonstepfamily Members by Research Area

Family status	Members' conditions							
	Records review		MATS instrument (Site 1 only)		Focus group interviews (Site 1 only)*		Total	
	n	%	*n*	%	*n*	%	*N*	%
Nonstepfamily or divorce	113	38	14	42	3	36	127	39
Stepfamily or divorce	184	62	10	58	5	63	194	61
Total	297	100	24	100	8	100	321	100

*All focus group participants were part of the group who completed the MATS instrument. Their scores were not added to the final total.

Assessing the impact of members' characteristics across all of these distinct groups is necessary to describe comprehensively the range of family conditions found in the USAF member population. If just "remarriage," "having stepchildren," and "being a stepparent" criteria were the only valid criteria defining a USAF member with stepfamily conditions, then the full scope of the impact of parental divorce, remarriage, and stepfamily status on members would be missed. Thus, the actual number of USAF members at time of referral incident who were strictly stepparents with stepchildren or adult stepchildren with stepchildren of their own (48 possible members at most) was far fewer than the single, married, divorced, or remarried members whose parents were divorced or remarried (n = 165, 55%).

For the total study sample, including the survey and focus groups, 199 (67%) members met the stepfamily and divorce criteria. As seen in Table 4, there were many single USAF members, 187 (63%) without stepchildren, not divorced, or remarried. However, 100 (54%) of these members had parents with divorce (n = 39, 21%) and remarriage (n = 61, 33%) conditions, subsequently qualifying the members as stepchildren or stepsiblings as well as adult children with histories of maritally conflicted parents.

Of all sample members with divorced parents, there were 35 (57%) married members, 20 (60%) divorced members, and 9 (60%) remarried members. If only members with remarried parents were counted, 96 (32%) were counted. If only members with divorced-only parents were counted, 69 (24%) were counted. If only

Table 4

Study Criteria for Members' Family Conditions

Status of member	Members' parents							
	Intact		Divorced		Remarried		Total	
	n	%	*n*	%	*n*	%	*N*	%
Never married	87	66	39	57	61	64	187	62.5
Married	26	20	18	26	18	19	62	21
Divorced	13	10	11	16	9	8	33	11.5
Remarried	6	4	1	1	8	8	15	5
Total	132	100	69	100	96	100	297	100

members themselves with a history of divorce or remarriage were counted, there were 48 (16%). When all three of these categories were combined, there were 213 separate cases (72%) that met study criteria, meaning that there were 24 extra cases that crossed categories and created combinations of other variable levels. Although these observations of various marital status combinations met the criteria for the study, few cases actually contained all the specified criteria simultaneously.

An examination of each variable level explains the range of combinations and describes the larger scope of single members' family conditions. Slightly more than one third (n = 30, 43%) of the sample members were nonsingle members with divorced parents. Similarly, nearly one third (n = 35, 36%) of the sample members were nonsingle members with remarried parents. As with the previous variable levels, one third (n = 45, 34%) of the sample members were nonsingle members with intact parents. Thus, in all cases of parental relationships, there were two thirds more single members than other types of members.

Looking at only members with a history of divorce or remarriage of their own regardless of parental history (n = 48, 16%), these members numbered less than one fifth of the sample. When the three parental categories were combined across nonsingle variable levels (married, divorced, and remarried), there were 110 cases (37.5%). Again, this result was nearly one third of the sample and indicated the predominance of single members in the sample. Other frequency analyses not listed here indicated that there were 24 sample cases that crossed "family conditions" categories and created other multiple combinations of variable levels.

Although these observations of various family status combinations met the criteria for the study, few cases actually contained all the specified criteria simultaneously.

Research Question 2

What are the demographic, career, and clinical characteristics of the members with and without stepfamily and divorce conditions in the three substance abuse programs?

Demographic Characteristics

Stepfamily and Divorce Conditions

The characteristics found through each of the five variables indicated the predominant type of members with stepfamily and divorce conditions. As presented in Table 5, the members were mostly male, in the youngest age bracket, never married, lived in base dormitories, and had no children. The variable marital status had combinations within members' self or parents, which qualified the members' family conditions into the discrete variable levels. As such, most of the sampled members did not have stepfamilies of their own but seem to have come most often from their parents' stepfamily and divorce arrangements.

The gender of the members in alcohol treatment was nearly all male. Few differences were found in percentages and raw numbers between each site. The number of females by each site and combined was still only one-tenth of the entire sample.

Table 5

Demographic Characteristics of Members with Stepfamily and Divorce Conditions

Variables	Site 1 AMC		Site 2 ACC		Site 3 AFMC		Total	
	n	%	*n*	%	*n*	%	*N*	%
Gender								
Male	60	92	48	89	57	88	165	90
Female	5	8	6	11	8	12	19	10
Age								
18-24	40	61	45	83	48	74	133	72
25-34	18	28	9	17	13	20	40	22
35+	7	11	0	0	4	6	11	6
Marital status								
Never married	30	46	35	65	36	55	101	55
Married	14	22	12	22	9	14	35	19
Divorced	21	32	7	13	20	31	48	26
Residence location								
Dormitory	31	48	27	50	34	53	92	50
Base housing	18	28	11	20	5	8	34	19

Table 5 (*continued*)

Variables	Site 1 AMC		Site 2 ACC		Site 3 AFMC		Total	
	n	%	*n*	%	*n*	%	*N*	%
Community	16	24	16	30	25	39	57	31
Children in home								
Yes	18	28	9	17	17	26	44	24
No	47	72	45	83	48	72	140	76
Total at each site	65	100	54	100	65	100	184	100

Note. AMC = Air Mobility Command mission, ACC = Air Combat Command mission, and AFMC = Air Force Material Command mission.

More than 70% of these members in alcohol treatment were between 18 and 24 years old. The number of members in the next higher bracket was only half of that found in the first bracket. Members who were 35 years old or older comprised the smallest group.

Members with stepfamily and divorce conditions who had never married made up half of those in treatment. Whereas each site differed by about 10%, there was a 19% difference between Sites 1 and 2. However, Sites 1 and 3 were most similar in stepfamily and divorced members, whereas Site 2 had the fewest of that type.

Most of the stepfamily and divorced members in treatment lived in the base dorms. In all sites, these members were half of the sample. All sites did not differ with respect to whether or not members lived on base housing or in the community was less distinct by site. Site 1 and Site 2 were evenly distributed both on base housing and the community. Site 3 had the most members living in the community. With most members residing in base dormitories, followed by privately contracted community residences and by base housing residences, Site 1 did not follow this pattern.

Of the stepfamily and divorced members in treatment for alcohol, 75% did not have children residing with them. Members at Sites 1 and 3 were most alike in that members had twice as many children as the members at Site 2. Yet, for the number of children not in the home, Site 2 was nearly the same as the other sites. This finding suggests that base location might have influenced whether members

have children at all or have children living with them. In either case, Site 2 appeared less favorable to having children reside with members or that members at Site 2 had fewer children (or none) residing with them.

Nonstepfamily and No-divorce Conditions

Although there were fewer members of the sample in this group, their characteristics indicated similarity to the predominant type of members with stepfamily and divorce conditions found above. These data were similar in most variable levels to stepfamily and divorce conditions members. As shown in Table 6, the members were mostly male, in the youngest age bracket, never married, lived in base dormitories, and had no children. Thus, overall, both types of members were similar to each other in all variables but family status.

The data also indicated that the sample was nearly completely made up of male members. The percentage of males differed by as much as 14%. Overall, the data indicated that of the nonstepfamily and no-divorce members in alcohol treatment there were fewer females at Sites 2 and 3.

Most nonstepfamily and no-divorce members in treatment were in the youngest age category. The number of members in the next higher bracket was five to six times fewer than found in the first bracket. Except for Site 2, members who were 35 years old or older comprised the smallest group.

Nonstepfamily and no-divorce members in treatment who had never married made up more than 70% of this group at each site. By definition, this variable did not have the category of divorce. As such, there were only two categories in which

Table 6

Demographic Characteristics of Members with Nonstepfamily and No-divorce Conditions

Variables	Site 1 AMC		Site 2 ACC		Site 3 AFMC		Total	
	n	%	*n*	%	*n*	%	*N*	%
Gender								
Male	39	83	37	97	26	93	102	90
Female	8	17	1	3	2	7	11	10
Age								
18-24	38	81	28	74	22	79	88	78
25-34	7	15	4	10	4	14	15	13
35+	2	4	6	16	2	7	10	9
Marital status								
Never married	38	83	28	74	20	71	87	77
Married	8	17	10	26	8	29	26	23
Divorced	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Residence location								
Dormitory	36	77	22	58	15	53	73	64
Base housing	5	10	3	8	3	11	11	10

Table 6 (*continued*)

Variables	Site 1 AMC		Site 2 ACC		Site 3 AFMC		Total	
	n	%	*n*	%	*n*	%	*N*	%
Community	6	13	13	34	10	36	29	26
Children in home								
Yes	5	11	7	18	3	11	15	13
No	42	89	31	82	25	89	98	87
Total at each site	47	100	38	100	28	100	113	100

Note. AMC = Air Mobility Command mission, ACC = Air Combat Command mission, and AFMC = Air Force Material Command mission. n/a = not applicable.

members' data could fall: (a) married and (b) never married. This occurrence increased the number of members within these variable levels.

Most of the nonstepfamily and no-divorce members in alcohol treatment lived in the base dorms. Of the members living in base dorms, most were at Site 1. Of the variable levels, the fewest members lived in base housing, although twice as many members lived in the community as in base housing. Regarding the level of living in the community, members at Site 1 did not follow the pattern of those at Sites 2 and 3.

Most of the nonstepfamily and no-divorce members in alcohol treatment did not have children in their homes. Percentages indicated that at least 80% of the members did not have children in their residence.

Career Characteristics

Stepfamily and Divorce Conditions

The characteristics found through each of these variables indicated the most common type of member meeting stepfamily and divorce criteria. Table 7 displays the number and percentage in each variable level, showing that the members were mostly junior enlisted, held operations duties, had been in the service the least number of years, had been on base the least number of years, and were returned to duty status most often. Moreover, in the most frequent level of each variable, the members made up no less than two thirds of the group. Thus, these members more often were found to have circumstances at the first level of each variable.

Table 7

Career Characteristics of Members with Stepfamily and Divorce Conditions

Variables	Site 1 AMC		Site 2 ACC		Site 3 AFMC		Total	
	n	%	*n*	%	*n*	%	N	%
Rank								
E1-E4	48	74	49	91	54	83	151	82
E5+	71	26	5	9	11	17	33	18
Air Force Specialty Code								
Operations	36	55	37	68	43	67	116	63
Support	29	45	17	32	21	33	67	37
Type in service								
0-4 years	42	65	37	68	45	69	124	67
4-8 years	9	14	15	28	11	17	35	19
8-12 years	4	6	1	2	4	6	9	5
12+ years	10	15	1	2	5	8	16	9
Time on station								
0-2 years	32	50	40	74	46	71	118	65
2-4 years	16	25	11	20	12	19	39	21

Table 7 (*continued*)

Variables	Site 1 AMC		Site 2 ACC		Site 3 AFMC		Total	
	n	%	*n*	%	*n*	%	N	%
4-6 years	12	19	3	6	6	8	21	11
6+ years	4	6	0	0	1	2	5	3
Duty determination								
Returned to duty	52	80	36	67	45	69	133	72
Discharged by incident	12	18	18	33	18	28	48	26
Retired or confined	1	2	0	0	2	3	3	2
Total at each site	65	100	54	100	65	100	184	100

Note. AMC = Air Mobility Command mission, ACC = Air Combat Command mission, and AFMC = Air Force Material Command mission.

The variable of rank indicated that most stepfamily and divorced members in alcohol treatment were the most junior of enlisted members. More than 75% of those members were in this group and by definition at the laborer or apprentice level. Site 2 had the least amount of members in ranks higher than E1 to E4, whereas Site 1 had the most members in higher ranks. Earlier statistical analyses performed on this variable showed that some levels of the variable had too few cases for measurement; therefore, data were recoded. The recoded variable reflected the lack of officers and higher ranking enlisted members with incident referrals. Thus, officers and higher ranking enlisted members comprised one variable level and the junior enlisted members comprised the other variable level.

Two thirds more stepfamily and divorced members in alcohol treatment held operation jobs than support jobs. Site 3 had the highest number of members in operation jobs and the lowest in support jobs, whereas Site 1 numbers were the converse of those numbers.

Stepfamily and divorced members in alcohol treatment with 4 or fewer years in the USAF were more than two thirds of all such members. Site 3 had the most members who had been in the USAF the shortest period of time. Site 2 had almost twice as many members who had been in the service from 4 to 8 years than did the other sites. At each site, there were few members who had been in the service from 8 to 12 years. However, Site 3 had more members in the service 12 or more years than did the other sites.

There were twice as many stepfamily and divorced members in alcohol treatment with 2 or fewer years on station than those with more years on station. However, Site 1 represented only half of such members, whereas Sites 2 and 3 represented more than 75%. Of members on base from 2 to 4 years, all sites were about equal. Of members on base 4 or more years, Sites 2 and 3 had the fewest number. Site 1 had more members with more time on station than the other sites.

More than two thirds of stepfamily and divorced members in treatment were returned to duty rather than discharged, retired, or confined. Site 1 returned the most members, whereas Sites 2 and 3 each discharged one third of their members.

Nonstepfamily and Divorce Conditions

The characteristics found through each of these variables indicated the most common type of member meeting nonstepfamily and no-divorce criteria. Table 8 displays the number and percentage in each variable level, showing that the members were mostly junior enlisted members, held operations duties, had been in the service the fewest years, had been on base the fewest years, and were returned to duty status most often. Moreover, in the most frequent level of each variable, the members made up no less than two thirds of the group. Thus, these members were found more often to have circumstances at the first level of each variable.

Overall, the variable of rank indicated that approximately 80% of nonstepfamily and no-divorce members in treatment for alcohol were the most junior ranking of enlisted members. Site 2 had the fewest members in ranks higher than E1 to E4, whereas Site 1 had the most numbers of members in ranks higher

Table 8

Career Characteristics of Members with Nonstepfamily and No-divorce Conditions

Variables	Site 1 AMC		Site 2 ACC		Site 3 AFMC		Total	
	n	%	*n*	%	*n*	%	*N*	%
Rank								
E1-E4	42	90	30	79	24	86	96	85
E5+	5	10	8	21	4	14	17	15
Air Force Specialty Code								
Operations	35	75	30	81	21	75	86	77
Support	12	25	7	19	7	25	26	23
Type in service								
0-4 years	40	84	26	68	20	71	86	76
4-8 years	3	7	6	16	5	18	14	12
8-12 years	1	2	2	5	0	0	3	3
12+ years	3	7	4	11	3	11	10	9
Time on station								
0-2 years	34	72	28	74	22	78	84	74
2-4 years	7	15	7	18	3	11	17	15

Table 8 (*continued*)

Variables	Site 1 AMC		Site 2 ACC		Site 3 AFMC		Total	
	n	%	*n*	%	*n*	%	*N*	%
4-6 years	4	9	3	8	2	7	9	8
6+ years	2	4	0	0	1	4	3	3
Duty determination								
Returned to duty	39	83	26	68	27	96	92	81
Discharged by incident	8	17	9	24	1	4	18	16
Retired or confined	0	0	3	8	0	0	3	3
Total at each site	47	100	38	100	28	100	113	100

Note. AMC = Air Mobility Command mission, ACC = Air Combat Command mission, and AFMC = Air Force Material Command mission.

than E1 to E4.

More than 75% of nonstepfamily and no-divorce members in alcohol treatment held operation jobs than support jobs. Site 3 had the most such members in operation jobs and the fewest in support jobs, whereas Site 1 showed the converse.

Nonstepfamily and no-divorce members in alcohol treatment with 4 or fewer years in the USAF were more than 75% of all such members. With the exception that Site 2 had the fewest number of such members in the USAF 4 to 8 years, all sites were similar to each other at all remaining variable levels.

Of the time on station variable, nonstepfamily and no-divorce members in alcohol treatment with 2 or fewer years were more than 75% of all such members. All sites were similar to each other at all remaining variable levels

More than 80% of nonstepfamily and no-divorce members in alcohol treatment were returned to duty rather than discharged, retired, or confined. Site 3 had a higher return rate than Sites 1 and 2. Site 3 also discharged the least number of such members. Whereas Sites 1 and 3 had no retirements or confinements associated with duty determination, 8% of such members did so at Site 2.

Clinical Characteristics

Stepfamily and Divorce Conditions

The characteristics found through each of these variables indicated the most common type of member meeting stepfamily and divorce criteria. Table 9 displays the number and percentage in each variable level, showing that the members

Table 9

Clinical Characteristics of Members with Stepfamily and Divorce Conditions

Variables	Site 1 AMC		Site 2 ACC		Site 3 AFMC		Total	
	n	%	*n*	%	*n*	%	*N*	%
Referral incidents								
1	53	81	42	78	50	77	145	79
2+	12	19	12	22	15	23	39	21
Appointments								
1-5	40	62	36	67	18	28	94	51
6-10	2	3	4	7	20	31	26	14
11-15	8	12	2	4	0	0	10	6
16-20	5	8	1	2	2	3	8	4
20+	10	15	11	20	5	38	46	25
History of suicide								
None	61	94	51	94	62	95	174	95
Ideations, gestures, attempts, completions	4	6	3	6	3	5	10	5

Table 9 (*continued*)

Variables	Site 1 AMC		Site 2 ACC		Site 3 AFMC		Total	
	n	%	*n*	%	*n*	%	*N*	%
History of abuse								
No history	45	69	43	80	51	79	139	75
Offender history	6	9	4	7	6	9	16	9
Victim history	14	22	7	13	8	12	29	16
Diagnosis								
No diagnosis	19	29	25	46	35	54	79	43
Alcohol diagnosis	25	39	22	41	29	44	76	41
Other diagnosis	21	32	7	13	1	2	29	16
Total at each site	65	100	54	100	65	100	184	100

Note. AMC = Air Mobility Command mission, ACC = Air Combat Command mission, and AFMC = Air Force Material Command mission.

mostly had one referral incident, had fewer than six appointments, did not have a history of suicide, did not have a history of abuse, and were not diagnosed about as much as they were with an alcohol diagnosis. The first level of each variable of all three sites posted the greatest number and percentage of these members. However, some differences in level between Sites 2 and 3 emerged and are described below.

Almost 80% of stepfamily and divorced members in alcohol treatment had only one referral incident. The percentages of members with two or more incident referrals were similar across all of the sites.

Of all stepfamily and divorced members in alcohol treatment, about half were found to have had one to five scheduled appointments in the program. The number of appointments varied greatly after that at each site, but when combined, there were still fewer than at any other grouping of appointments kept. Twenty-five percent of all such members had 20 or more appointments. However, of the three programs that met with members 20 or more times, Site 3 had twice as many members as did Site 1.

Almost all of the stepfamily and divorced members in alcohol treatment did not have a history of suicide ideations, gestures, attempts, or completions. This finding was consistent for each site. Thus, most members had not displayed suicidal behavior.

Of the stepfamily and divorced members in alcohol treatment, 75% had no histories of abuse as either offender or victim. Each site was similar to the others

in percentages, except that Site 1 had more members with victim histories. Determining from the data where members' abuse incidents occurred was not possible. Thus, it is unknown why Site 1 had a greater number of members with victim histories.

A most common diagnosis was not found among stepfamily and divorced members in alcohol treatment. Except for the other diagnosis variable level at each site, all sites were similar to each other at other variable levels. Thus, such members received no diagnosis or an alcohol diagnosis about equally as often, except for diagnoses of other problem types.

Nonstepfamily and Divorce Conditions

The characteristics found through each of these variables indicated the most common type of member meeting nonstepfamily and no-divorce criteria. Table 10 displays the number and percentage in each variable level, showing that the members mostly had one referral incident, had fewer than six appointments, did not have a history of suicide, did not have a history of abuse, and were not diagnosed about as much as they were with an alcohol diagnosis. The first level of each variable of all three sites posted the greatest number and percentage of these members.

Almost 90% of nonstepfamily and no-divorce members in alcohol treatment had only one referral incident. Site 2 had twice as many members with two or more incident referrals than did the other sites. Site 2 also had 20% fewer such members who had one incident referral.

Table 10

Clinical Characteristics of Members with Nonstepfamily and No-divorce Conditions

Variables	Site 1 AMC		Site 2 ACC		Site 3 AFMC		Total	
	n	%	*n*	%	*n*	%	*N*	%
Referral incidents								
1	39	83	25	66	24	86	88	88
2+	8	17	13	34	4	14	25	12
Appointments								
1-5	34	72	27	71	14	50	75	67
6-10	1	2	2	5	6	21.5	9	8
11-15	1	2	2	5	2	7	5	4
16-20	4	9	1	2	0	0	5	4
20+	7	15	6	16	6	21.5	19	17
History of suicide								
None	46	98	25	95	25	89	106	95
Ideations, gestures, attempts, completions	1	2	2	5	3	11	6	5

Table 10 (*continued*)

Variables	Site 1 AMC		Site 2 ACC		Site 3 AFMC		Total	
	n	%	*n*	%	*n*	%	*N*	%
History of abuse								
No history	43	92	35	92	26	93	104	92
Offender history	1	2	2	5	0	0	3	3
Victim history	3	6	1	3	2	7	6	5
Diagnosis								
No diagnosis	22	47	23	60	21	75	66	58
Alcohol diagnosis	12	25	11	29	6	21	29	26
Other diagnosis	13	28	4	11	1	4	18	16
Total at each site	47	100	38	100	28	100	113	100

Note. AMC = Air Mobility Command mission, ACC = Air Combat Command mission, and AFMC = Air Force Material Command mission.

Of all nonstepfamily and no-divorce members receiving appointments, two thirds were found to have had one to five scheduled contacts in the program. The next three variable levels were far less than the first in percentage of members' appointments. The last level had similar amounts compared to the previous three levels. However, when numbers were compared to the other sites, Site 3 had the least number of the first level, a slightly higher amount in the second, and similar in the last three levels. Yet, the percentages of these levels differed when Site 3 was compared to the other sites.

Nearly all nonstepfamily and no-divorce members had no history of suicide ideations, gestures, attempts, or completions. This pattern was consistent at each site. However, Site 3 had the most members with a history of some type of suicidal behavior or event. When and where the suicidal activities occurred were not ascertainable from the data collected. Thus, why Site 3 had more members with such histories is unknown.

More than 90% of nonstepfamily and no-divorce members had no history of abuse as either offender or victim. Each site was similar to the others in percentages of members at all variable levels, except that there were no members with offender histories at Site 3. Again, it could not be determined from the data collected why there were members at Site 3 without such histories.

Most nonstepfamily and no-divorce members had no diagnosis. When receiving an alcohol diagnosis, all sites were similar to each other. However, more members received no diagnosis than other alcohol diagnoses than such members at

the other sites. Thus, the members represented a clinically diagnostic pattern in that they received no diagnosis or an alcohol diagnosis about equally as often, except for diagnoses of other problem types.

Research Question 3

Do USAF members with stepfamily and divorce conditions who received outpatient substance abuse program services have equivalent characteristics to the general USAF population? Overall, members sampled in this study were equivalent more often in the specified characteristics to their peers. The sample had a greater representation of five characteristics in members than was found in members across the general USAF. Compared to the general USAF population, in this sample, the members more often were male, between 18 and 24 years old, single, enlisted, and had been on an assigned base for less than 2 years. Further, equivalencies were also found among these five variables between the survey group, record review, sites, and Major Command areas. Most important to this study was the finding that members were similar in the distribution of the stepfamily and divorce conditions across the three research sections (records review, survey instrument, and focus groups) and the other two mid-organizational levels.

Conversely, when compared to general USAF members, in this sample, there were fewer members with children, more members in operational duties, and more who had been serving the least amount of time. The equivalencies found among these three variables were also found in the general USAF, survey group, record review, Major Command, and the sites. Data regarding the outstanding two

variables (residence and duty determination) were not included because USAF personnel offices do not collect data of this type.

However, although some of the equivalencies between the three sections of research did not match the USAF population, the reasons for this occurrence emerged to form a clearer profile of these members whose distinctive characteristic is involvement in alcohol treatment. The participants in the survey and the group interview of the sample were also assessed for equivalency. The record review established a baseline of data by which to compare the data of sample members in the other two research sections. In general, most of the variables indicated equivalency between the surveyed group and members' data from the record review.

Equivalencies of the Main Sample and General USAF

The equivalency assessments examined the variables that were available from USAF personnel data sources and were found comparable to the characteristics of the study. The available demographic variables of active-duty personnel were gender, marital status, age, and family members in home. The available career variables were rank, Air Force Specialty Code, time in service, and time on station.

Most of the variables of interest to this study were obtained from USAF databases, yet several others were not. Again, the unavailable variables were the general USAF members' residence (demographic category), members' status of

return to duty (career category), and all five variables encompassing the clinical category. Although race data of the USAF population were available, comparable data were not included in this study.

Tables 11 and 12 list the USAF data found (Air Force Personnel Center, 2000) regarding calendar year 2000 and display the available data found in the sample. Overall, the assessment of only general USAF members' characteristics indicated that most members were young, enlisted, male, married more than officers were, single more than officers were, divorced more than officers were, more often had children in their homes than officers did, occupied mostly support positions, were even in the number of years served, and had been at their base for 4 years or less. Although there were disparities to the sample in smaller analyses of ranks, rank by time in service, rank by age, and gender, other variables indicated general equivalencies among the categories, including number of years served.

Gender

More men were found in the sample than overall in USAF personnel. Whereas the USAF was represented by more than 80% of males, 90% of males were represented in the sample. This finding indicates an example of variable concentration. The distribution of the variable gender found among USAF members was represented as the extreme of the variable.

Table 11

Equivalency of Demographic Characteristics: Stepfamily/Divorced and Nonstepfamily/No Divorce

Variables	Sample (combined)			
	USAF		All sites	
	n	%	*N*	%
Gender				
Male	284,616	81	292	90
Female	66,762	19	38	10
Age				
18-24	114,812	33	237	72
25-34	125,035	36	64	19
35+	110,833	31	29	9
Marital status				
Never married	111,764	31	200	60
Married	216,976	62	73	22
Divorced	23,139	7	57	18
Residence location				
Dormitory	n/a	n/a	165	56
Base housing	n/a	n/a	45	15
Community	n/a	n/a	86	29
Children in home				
Yes	166,680	48	64	20
No	184,519	52	242	80

Note. n/a = not applicable.

Table 12

Equivalency of Career Characteristics: Stepfamily/Divorced and Nonstepfamily/No Divorce

Variables	Site			
	USAF		Sample (combined)	
	n	%	*N*	%
Rank				
Enlisted	282,356	76	325	99
Officer	69,023	24	5	1
Air Force Specialty Code				
Operations	125,129	44	223	68
Support	157,227	56	103	32
Time in service				
0-4 years	118,847	34	200	66
4-8 years	56,183	16	67	22
8-12 years	43,915	13	11	3
12+ years	126,863	37	27	9
Time on station				
0-2 years	209,786	60	133	54
2-4 years	90,115	25	99	41
4-6 years	27,985	8	6	2.5
6+ years	23,218	7	6	2.5
Duty determination				
Returned to duty	n/a	n/a	225	76
Discharged by incident	n/a	n/a	66	22
Retired or confined	n/a	n/a	6	2

Note. n/a = not applicable.

Age

More than two thirds of the sample members were younger than 25 years old. Moreover, in that age bracket, sample member percentages were more than three times those of members found in USAF data. Whereas the USAF member age distribution was about evenly split between three age divisions, the sample was not. Again, this sample variable likely may have indicated an extreme representation of USAF data.

When commissioned and noncommissioned ranks were examined, the numbers of 17- to 24-year-old members in the service at the same time was greater in the enlisted force than in the officer force. The explanation for this difference is that educational differences exist between the groups because of the inherent attributes of awarded rank. While the one group had joined the work force through enlistment, the other group had extended their education and had completed college while the former group had remained in their enlistment and matured into the next age bracket. The number of officers in the same age group at college completion will always necessarily be fewer than the number of enlisted members. Thus, enlisted members may have only begun their experimentation with alcohol, whereas officers may have had experiences and gained some level of control.

Marital Status

The percentages of members who had never married in the sample were twice those found in the general USAF membership. Accordingly, the percentages of members who were married in the sample were three times fewer than those

found in the USAF data. However, the percentages were twice those of divorced members found in the sample than those of the USAF data.

Children in Home

Of the sample, the number of members not having family members in their homes was 80%. However, the USAF data indicated that members were about evenly split in this variable. When examining this variable by rank, the number of all USAF officers who had family members in their homes was 25,702 (37%), whereas 141,158 (50%) of all USAF enlisted members had family members in their homes. The E1 to E4 members were the highest proportion (87%) of those with no children in their homes.

Military homes are characterized as households contracted, owned, or assigned to military member(s) who may have been residing on a USAF installation but not necessarily. Thus, determining how many members of each rank and where each type placed their children was not possible. Since this variable represented the sample showing that most members did not have children, member equivalence between the USAF population and the sample does not appear strongly similar. Yet, this variable also seemed to indicate an extreme instance of USAF data.

Rank

USAF data indicate that the ratio of officers to enlisted members was approximately three to one. The sample ratio indicates that for every one officer in

treatment there were nine enlisted members. As in previous cases between the sample and the general USAF, this variable also appears to have been an extreme representation.

Interestingly, within both categories of rank, there was a steady decrease in personnel since 1987, whereas the annual budget for the USAF showed a modest increase up to $71 billion. The number of enlisted personnel were the lowest since 1947, whereas the number of officers were the lowest since 1950. Rank reductions are linked to national fiscal budget policies and overall may represent fewer personnel accomplishing mission objectives with more powerful technology, yet obtained at a higher cost. In 2000, the fiscal budget for the USAF was approximately $66 billion, a relatively stable amount compared to the preceding 6 years. For example, not since 1979 when the same budget was $69 billion has the budget been as low. In 1977, the budget was the last time until 2000 that the USAF budget was more than $70 billion. The USAF budget peaked in 1985 and had a steady decline until leveling in 1994. Some USAF sources report that a reduced budget is a primary cause of personnel being overworked and having mental stress that leads toward decreased competency, frustration, and lower retention (Crawley, 2002).

Duty Position

More than two thirds of the sampled members held operational jobs while the remainder held support jobs. Whereas in the USAF there were more members performing support duties, the sample had more members performing operational

duties. Since the data indicate a reversal of job types, this variable indicated that the equivalency in the sample was not strongly related to general USAF members. According to USAF statistics, members in operational duties or support were almost evenly divided, with slightly more members having support duties.

Members with operational jobs primarily have direct contact with aircraft and aircraft systems or flight command and those systems. Members with support jobs have indirect or no aircraft contact (and flight command) and, for the most part, comprise the organization of members with roles that maintain members found in operational positions. Medical positions are included in the support position category. Furthermore, only data concerning enlistees were taken because there were only five officers found within the study sample. These data would not contribute to the gross characterization of the target group. However, comparable enlisted member data were obtained for the lower USAF organizational divisions of Major Command, site, and sample.

Time in Service

The variable called time in service defined the length of time members were in the USAF or possibly included their time spent in another military branch from previous service. Time in service was grouped into 4-year blocks because most enlistments (and reenlistments) are contracted for that period of time. In the sample, there were nearly twice as many members comprising those with first enlistments than those in the USAF. The number of members sampled who reenlisted once or more declined by more than half after the first term and did not

increase substantially in any other year. However, there were four times the number of general members staying in longer than sample members.

Time on Station

The variable called time on station defined how long members had been part of their base culture. The sample and USAF data were similar for members who had been on base 2 years or less. Of the approximately 60% of USAF members who had been on base from 0 to 2 years, the percentage of those members remaining on station after that time period declined sharply in each subsequent interval. Although a similar pattern was found in the sample members, the percentages dropped most after the second level.

Equivalencies in Other Organizational and Study Levels

Major Command data were not analyzed for equivalencies as the general USAF personnel were, but they were collected to examine the pathways of characteristic data through and assess whether or not a substantial impact was detected. A brief view of the findings is provided in the following sections.

Major Commands

As found in the sample and USAF equivalency, similar disparities were found in the Major Commands among the distributions of ranks, ranks by time in service, ranks by youngest age, and gender. However, all other available variables indicated similar equivalencies among and across the categories of each Major

Command.

A difference that appeared in this analysis indicated a shift between the general USAF member data and that of the sampled members. The shift was seen in the differences between operational and support jobs among the Major Commands. Almost two thirds of the enlisted members occupied operational positions at Air Mobility Command bases, more than half of the operational positions at Air Combat Command bases, and just more than one third at Air Force Material Command bases. Considering these data, the Major Commands accounting for this shift were the Air Mobility Command and Air Combat Command.

This occurrence may be linked to the disparate nature of the mission definitions among them. The Air Mobility Command and Air Combat Command were predominantly operationally oriented, whereas the Air Force Material Command had even more support to operational positions compared to the USAF overall. Considering the reversing trend in Air Force Specialty Code (duty position) overall, the three Major Commands provided an equivalent group in which to trace the distribution of variables.

Sites

As with the above data, site data were not analyzed for equivalencies as general USAF personnel were, but they were collected in order to locate shifts of variable data. A brief view of the findings is provided below.

An equivalency determination important to understanding the sample concerned the data collection sites. The research questions were not planned to investigate whether or not site differences existed but made allowances for comparisons to trace where changes occurred. The three bases where data collection occurred were selected because of their separate missions, geographical locations with regard to cultural region influence, and metropolitan economy and proximity.

The disproportionalities found in the USAF and Major Commands regarding the variables of gender, rank, and marital status also extended through each site. However, this assessment also indicated that most members were the youngest, male, enlisted, married more than officers were, single more than officers were, divorced more than officers were, more often had children in their homes than did officers, were even in the number of years served, and had been at their base for 4 years or less. One difference emerged from this assessment.

The duty position variable of the sites indicated a growth trend in the two job divisions when compared with the Major Command and USAF. The USAF had a greater proportion of support to operational jobs, and the Major Commands showed a reversal of job types towards more operational to support jobs. The sites' assessments had an increase in the proportion of operational to support jobs. Overall, the unique nature of each base's function became more distinct from overall USAF data.

The disparities found in the sites that were similar to those of the Major Commands and USAF data did not indicate substantial deviations. With the exception of job duty and marital status, the other variables indicated equivalency among and across each of the Major Command categories.

MATS Instrument and Focus Group

An important finding was that the proportions of both types of members' family conditions reflect the data displayed in Table 1. Ten (42%) members met inclusion criteria for the "no conditions," meaning that they and their parents' relationships were intact. Tabulation of these data and others of the study as well as organizational levels are given in Tables 11 and 12. Twenty-four (92%) surveys were kept for analysis. With regard to family criteria equivalency, 14 (58%) members, after being presented the inclusion criteria, determined that they met the criteria by divorce or remarriage within their own or their parents' histories.

Some data were not available in this section of the research. Regarding the variable children in home, the MATS survey was not constructed to request this information; consequently, data were not available. Regarding time in service and time on station, the MATS instrument was also not constructed to collect either variable; therefore, it is unclear how these data were acquired.

All participants in the two focus groups were selected from the specified treatment population. Because the focus group participants were from the same treatment group as the survey respondents, members shared many of the same characteristics. Due to the qualitative method of analysis for these groups,

statistically high numbers were not required (Barbour & Kitzinger, 1999; Edmunds, 1999; Fern, 2001; Krueger, 1994, 1998; Morgan, 1993; Stewart & Shamdanasi, 1990). However, some equivalencies existed among the group members and lend themselves well toward data analyses.

Summary

All variables of each research section of the sample indicated a similar relationship to the data found among the three sites, Major Commands, and USAF population. The broader USAF organizational levels served as a secondary data source by which to better describe the sample members. The sample demographic and career data identified the members as a more concentrated representation of those organizational levels across each variable. Recall that the members sampled in the record review section had received services from the outpatient substance abuse program from three clinical sites. Comparing the combined sample members with the remainder of the USAF, there were even more members in the sample who were male, younger, single, without children, enlisted, holding operational jobs, been in the service the least amount of time, and been on base the least amount of time.

Research Question 4

What are the similarities and differences between members with and without stepfamily and divorce conditions from outpatient alcohol treatment in substance abuse program services? The similarities of the members both with and without the

stepfamily and divorce conditions were found in the three groups of variables: (a) demographic, (b) career, and (c) clinical. Of the demographic variables, these members were alike in the distributions of gender and age. Members were also alike in the distributions of rank, time in service, time on station, and duty determination. These members were almost different because chi-square test of significance in duty determination was approached in the distribution between both member types. Of the clinical variables, these members were alike in the distribution of incident referrals, number of appointments, and suicidal history. Overall, of the 15 separate variables across the 3 categories, 9 variables showed similarity.

The differences of the members with and without stepfamily and divorce conditions were found in the remaining variables of the three categories. Of the demographic variables, these members were different in marital status, whether or not they had children, and where they resided. Of the career variables, the members were different in their duty positions. Of the clinical variables, the members were different in their histories of abuse and in their diagnoses. Overall, of the 15 variables, these members were different in 6 variables of the 3 categories. The probability values found in cross-tabulation analyses of all variables are given in Table 13.

Demographic Characteristics

This section further describes the fundamental commonalities of the two types of members' family circumstances through some of the basic shared life

Table 13

Distribution of Variable Significance

Variable	Type	
	Similarities	Differences
Demographic		
Gender	$\chi^2(1, N = 297), p = .87$	
Age	$\chi^2(2, N = 297), p = .15$	
Marital status		$\chi^2(2, N = 297), p = .0001$*
Children in home		$\chi^2(1, N = 297), p = .026$
Residence		$\chi^2(2, N = 297), p = .032$
Career		
Rank	$\chi^2(1, N = 297), p = .52$	
Duty position		$\chi^2(1, N = 297), p = .016$
Time in service	$\chi^2(3, N = 297), p = .346$	
Time on station	$\chi^2(3, N = 297), p = .346$	
Duty determination	$\chi^2(1, N = 297), p = .075$	
Clinical		
Incident referrals	$\chi^2(2, N = 297), p = .181$	
Appointments	$\chi^2(4, N = 297), p = .115$	
Suicide history	$\chi^2(1, N = 297), p = .98$	
Abuse history		$\chi^2(2, N = 297), p = .002$
Diagnosis		$\chi^2(2, N = 297), p = .016$

*Variable definition accounts for significance.

experiences found in typical USAF members. The numbers and percentages of members found in each demographic variable level are provided in Table 14.

Similarities

In terms of gender or age, no significant differences were found between the two types of members. For the variable gender, the results indicated that in the distributions of the type of members the observed frequency of males and females was almost identical to the expected frequency. Thus, most types of members were male. For the variable age, there were also equivalent numbers in both types of members from 17 through 24 years old, 25 through 34 years old, and 35 years old or older. Here, most types of members were the youngest of all members.

Differences

In terms of marital status, children in home, or residence, significant differences were found between the two types of members. For the variable marital status, the results indicated that the observed frequency of the three levels (single/never married, married at time of treatment, and divorced or remarried at time of treatment) across the types of members was significantly related. However, a test assumption regarding the independence of test variables may have been violated because these variables could be dependent on each other. By the variable design, frequencies of sample members without stepfamily and divorce conditions would not have the properties of the divorce or remarriage. Of all members, more than two thirds had never been married. Of the remaining one third, more than

Table 14

Demographic Characteristics by Family Type

Variables	Type					
	Stepfamily/divorce		Nonstepfamily/divorce		Total	
	n	%	*n*	%	*N*	%
Gender						
Male	165	62	102	63	167	63
Female	19	38	11	37	30	37
Age						
18-24	133	72	88	78	221	75
25-34	40	22	15	13	55	18
35+	11	6	10	9	21	7
Marital status						
Never married	101	55	87	77	188	66
Married	35	19	26	23	61	21
Divorced/remarried	48	26	0	0	48	13
Residence location						
Dormitory	92	50	73	64	165	57

Table 14 (*continued*)

Variables	Type					
	Stepfamily/divorce		Nonstepfamily/divorce		Total	
	n	%	*n*	%	*N*	%
Base housing	34	18	11	10	45	14
Community	57	32	29	26	86	29
Children in home						
Yes	44	24	15	13	59	18
No	140	76	98	87	138	82

half of those members were married, and less than half of those married had divorced. As mentioned, categorical differences of definition were involved in variable levels.

As indicated, more than one fourth of the members with stepfamily and divorce conditions were divorced, whereas there were no divorced members with nonstepfamily and no-divorce conditions. Yet, the number of both types of married members were comparable. However, the members with stepfamily and divorce conditions totaled 14 more in the first level of the marital status variable, 9 more in the second level, and 48 more in the third level. Despite the differences in raw numbers, the percentages of members with stepfamily and divorce conditions were less at the first two levels than were those of members with nonstepfamily and no-divorce conditions. Thus, according to analyses, the distribution of members with stepfamily and divorce conditions was less than expected in level one, similar to members without those conditions in level two, and far greater in level three. This finding translates into larger distributions of members, with stepfamily and divorce conditions having greater activity of marital change themselves. As given in Table 14, compared to members with nonstepfamily and no-divorce conditions, there were more stepfamily and divorced members who had been either unmarried or divorced.

For the variable residence, the distribution of the types of members in the observed frequency of the first level indicates that there were more of those with nonstepfamily and no-divorce conditions than expected. Stepfamily and divorce

conditions members outnumbered their counterparts when living in the dorms. However, there were fewer than observed within their distribution of family type. Conversely, there were more stepfamily and divorce conditions members found than expected living in on-base housing ($\chi^2(2, N = 296) = 6.89, p = .032$). About three fourths of these members maintained residences on their assigned bases. The number and distribution of all members living in off-base housing or in communities were similar. This finding may be interpreted to mean that these members relied on military housing twice as often as they did living within the local economy.

For the variable children in home, the distribution of the type of members in the observed frequency of the first level indicates that there were more of those with nonstepfamily and no-divorce conditions than expected. Stepfamily and divorce conditions members outnumbered their counterparts in having no children. However, there were fewer than observed within their distribution of family type. Conversely, there were more stepfamily and divorce conditions members with children than expected. These data were also recoded into two nominal data groups. The first group was composed of members who had never had children, and the second group was composed of members who had at least one child but possibly more living with them. Overall, stepfamily and divorce conditions members had fewer children more often than did their counterparts who had no children. In addition, stepfamily and divorce conditions members more often had more children than did their counterparts who had children. This finding may be

interpreted to mean that these stepfamily and divorce conditions members delay longer in having children yet later have more children than other members.

Career Characteristics

This section describes some of the typical areas that impact members' occupational records, which also lead towards an impact in their life experiences. The numbers and percentages of members found in each career variable level are provided in Table 15.

Similarities

In terms of rank, time in service, time on station, or duty determination, the two types of members were similar to each other. For the variable rank, the distributions of the types of members in the observed frequency of the first level E1 to E4 and the second level E5 to E9 plus officers (O3 and O4) were not significant. The second group comprised the management level, whereas the first group comprised the laborers. Earlier cross-tabulation analyses showed that cells had an insufficient count for testing; thus, these data were recoded into two nominal groups, which allowed testing to proceed. Most of the types of members were in the most junior ranks.

For the variable time in service, both types of members were also equivalent. Previous analyses also indicated lower than expected counts; thus, these data were recoded from six into four nominal groups. Each variable level was distinct from the other levels and indicated a similar pattern between both types of

Table 15

Career Characteristics by Family Type

Variables	Type					
	Stepfamily/divorce		Nonstepfamily/divorce		Total	
	n	%	*n*	%	*N*	%
Rank						
E1-E4	151	82	96	85	247	83
E5+	33	18	17	15	50	17
Air Force Specialty Code						
Operations	116	63	86	76	202	70
Support	67	37	26	24	93	30
Time in service						
0-4 years	124	67	86	76	210	71
4-8 years	35	19	14	12	49	16
8-12 years	9	5	3	3	12	4
12+ years	16	9	10	9	26	9
Time on station						
0-2 years	118	64	84	74	202	69

Table 15 (*continued*)

Variables	Type					
	Stepfamily/divorce		Nonstepfamily/divorce		Total	
	n	%	*n*	%	*N*	%
2-4 years	39	22	17	15	56	18
4-6 years	21	11	9	8	30	10
6+ years	5	3	3	3	8	3
Duty determination						
Returned to duty	133	72	92	81	225	76
Discharged by incident	48	26	18	16	66	21
Retired or confined	3	2	3	3	6	3

members. Most of the members declined in years of service after the first term, yet briefly elevated when members had 12 or more years. Most member types had been serving military duty for only 1 term.

For the variable time on station, both types of members were equivalent in distribution. More than two thirds of all members had been on base less than 4 years. As with the previous variable, these data were distinct at each level from the others. The pattern indicated a rapid decline with no elevation in numbers of the last level. Earlier analyses performed on these variables also indicated cells with a lower than expected count; thus, these data were recoded into four nominal groups. Most members had only been at their first assignment.

For the variable duty determination, there were equivalent numbers in the distribution of both types of members. Although this variable is technically a decision of the treatment provider, it was included in this group because of the direct impact to the members' careers. There was also a distinct pattern at each level of this variable. Overall, in the first level, there were more than three fourths of the members who returned to duty. Of the remaining two levels, the number of all members not returning to duty was far fewer than those who did return to duty. As in previous analyses, cells with a lower than expected count were present; thus, the data were recoded from four into two nominal groups. Most members of the two types were released from the treatment program.

Differences

In terms of duty position, significant differences were found between the two types of members ($\chi^2(1, N = 295) = 5.78, p = .016$). For the variable duty position, the results indicated that members' operational job distribution was greater in nonstepfamily and no-divorce members than in others. Raw numbers were greater in stepfamily and divorce members in both levels than were other members. However, a larger than expected proportion of those other members were found in operational positions. Thus, whereas most operational positions were staffed by stepfamily and divorced members, there was a smaller proportion who occupied those jobs. This finding could also be interpreted to mean that these members did not occupy those jobs as often as their type of distribution predicted.

Clinical Characteristics

This section describes the interface with service providers and program content as represented by total contacts and clinical groupings resulting from referral circumstances. The numbers and percentages of members found in each clinical variable level are provided in Table 16.

Similarities

In terms of the number of incident referrals, number of clinical appointments, or history of suicide, no significant differences were found between the two types of members. For the variable number of incident referrals, the results indicated that in the distribution of the types of members the observed

Table 16

Clinical Characteristics by Family Type

Variables	Type					
	Stepfamily/divorce		Nonstepfamily/divorce		Total	
	n	%	*n*	%	*N*	%
Referral incidents						
1	145	79	88	78	233	79
2	36	20	19	17	55	18
3+	3	1	6	5	9	3
Appointments						
1-5	96	52	75	67	171	59
6-10	26	14	9	8	35	11
11-15	10	5	5	4	15	5
16-20	8	4	5	4	14	4
20+	46	25	19	17	65	21
History of suicide						
Ideations, gestures, attempts, completions	10	5	6	6	16	6
None	174	95	106	94	280	94

Table 16 (*continued*)

Variables	Type					
	Stepfamily/divorce		Nonstepfamily/divorce		Total	
	n	%	*n*	%	*N*	%
History of abuse						
No history	139	76	104	92	243	84
Offender history	16	8	3	3	19	6
Victim history	29	16	6	5	35	10
Diagnosis						
No diagnosis	79	43	66	58	145	51
Alcohol diagnosis	76	41	29	26	105	33
Other diagnosis	29	16	18	16	47	16

frequency was much greater in the first level than in the other two levels. As in other analyses, the lack of expected counts in some cells required recoding; thus, these data were combined into three nominal groups. The results indicated that they were not significantly related in referral incidents. As a result, most members had only one alcohol incident.

For the variable number of clinical appointments, there were also equivalent numbers in the distribution of both types of members. More than half of all members had less than six appointments in treatment. The number of members' appointments declined sharply after that level. An increase was found in the number of members who received more than 21 appointments; however, overall this percentage was only one-fifth of all members. Data were also recoded in this variable, making four nominal groups. The results indicated that they were not significantly related in appointments. Thus, most members received from one to five appointments to satisfy program requirements for treatment release.

For the variable history of suicide, the results indicated that the observed frequencies of the two groups across the criterion variable were not significantly related in suicidal history. Many more members did not have a recorded history of suicidal ideations, gestures, attempts, or completions than those who did. Of all cases examined, only 1 member had completed a suicide, 5 members had made real attempts, 4 had made some type of gesture, and 7 had reported ideations of some type. These cases accounted for about 4.5% of the cases examined. Thus, most treatment members did not appear to have had self-harming behaviors.

Differences

In terms of duty history of abuse and diagnosis, significant differences were found between the two types of members. For the variable history of abuse, the results indicated that the observed frequency of the levels across the type of members was significantly related. From the original 10 categories describing subparts of abuse types, these data were recoded to form 3 nominal groups. The stepfamily and divorce members' incidence of abuse in both types as offender and victim was greater than their group distribution. These members were nearly five times more likely than members without stepfamily and divorce conditions to have been an offender or a victim. There were nearly twice the number of victims of abuse among stepfamily and divorce members than among other members. Accordingly, the distribution of stepfamily and divorce conditions members in the first level was less than expected in overall group distribution. Thus, those members more often experienced some type of abuse in their current or family of origin.

For the variable diagnosis, the results indicated that the observed frequency of the levels across the types of members was significantly related. Here, too, analyses indicated that data recoding was necessary; thus, three nominal groups were created. Of the stepfamily and divorce members, a greater distribution was found with alcohol diagnoses than in the other two levels. The third level was about equal to the expected distribution, whereas the first level was somewhat less than expected. Thus, these members received alcohol diagnoses more often than

did nonstepfamily and divorce conditions members.

Research Question 5

What are the attitudes and beliefs of USAF active-duty members with and without stepfamily and divorce conditions that indicate barriers to treatment in an outpatient substance abuse program? The attitudes of the USAF with stepfamily and divorced members were generally favorable toward helping services, yet less so than other members' attitudes. However, USAF stepfamily and divorced members' attitudes indicated that they perceived more barriers than nonstepfamily and no-divorce members. The beliefs of USAF members with stepfamily and divorce conditions were mostly concerned about their reduced or loss of control (or compromise) around their occupations, helping services, and family regarding authority, privacy, and group cohesion. The findings are divided in two sections: (a) the MATS instrument and (b) the focus group interviews. The MATS survey scores were examined first, followed by an analysis of the focus group interviews of members from alcohol outpatient treatment.

MATS Instrument

The MATS instrument was used to examine members' attitudes and perceptions regarding barriers to treatment services. This analysis allowed for the possibility that barriers to service may have originated from a member's perceptions and attitudes, originated from a service delivery structural problem, or some combination of the two. Since this instrument had only been used once before

on a different type of USAF group, this examination validated whether or not respondents' scores approximated the previous testing. Determining this outcome assisted in deciding whether or not the instrument was a valid survey to apply to these members. Scores indicated similarity; thus, the survey was considered as validly administered. The interrelatedness of the MATS respondents' questions indicated few differences in scores across all four categories of help-seeking attitudes (questions 6 to 17), career threat and source barriers (questions 1 to 5), office of primary responsibility ratings (questions 18 and 19), and help utilization (questions 20 and 21).

With regard to comparison of the help-seeking attitudes and perceptions toward mental health services between the average USAF member and the general population, Stone (1998) observed that USAF members had a significantly lower ATSPPHI score in positive attitudes than did civilians. Fischer and Farina (1995), the comparison study, found a mean score of 27.5, whereas Stone found a mean score of 25.1. For the present sample, the mean ATSPPHI score of 33.04 ($SD \pm$ 6.94) was higher than both previous mean findings and indicated an elevated favorable attitude among all members in this study.

Comparing respondents' views of help-seeking sources and favorable attitudes indicated how their positive views of help-seeking related to each type of member. When all the ATSPPHI scores were assessed across values of the first barrier, no significance was found. This finding indicated congruence between favorable attitudes and sources of help by type or that all respondents did not

perceive that any of the given helping sources presented barriers to seeking services.

Comparing all respondents' views of negative career impact and favorable attitudes indicated how their positive views of help-seeking related to a (hypothetical) threat to their job continuance in the USAF. As before, when the ATSPPHI scores were assessed across values of the second barrier, no significance was found. This result indicated congruence between favorable attitudes and sources of help by career threat or that all respondents did not perceive that any of the given career threats were barriers to seeking services.

Comparing respondents' views of the office of primary responsibility and favorable attitudes indicated how their positive views of help-seeking related to their attitudes toward the quantity and quality of mental health services specifically. When all ATSPPHI scores were assessed across values of the office of primary responsibility, no significant difference was found. This finding indicated congruence between favorable attitudes and the quantity and quality of mental health services in the USAF or that all respondents did not perceive that neither of the office of primary responsibility questions presented barriers to seeking services.

An analysis comparing all respondents' views of the office of primary responsibility and the first barrier value indicated how their perceptions of threat to career related to their attitudes toward the quantity and quality of mental health services or the office of primary responsibility specifically. As detailed in further analyses below, more respondents with perceptions that talking to any military

source hurts careers disagreed that the availability of USAF helping services could assist them with problems. Their disagreement indicated that perceptions of career threat in the availability of USAF helping services presented barriers to seeking help. The unknown aspect of this finding was whether the respondents believed there simply was not enough help available or that what help was available was not enough of the right type. The second question of the office of primary responsibility questions helped answer this possibility.

No significance was found when all respondents who felt threats to their careers were asked whether or not mental health professionals inflated problems. All respondents may not have perceived barriers to service because of the quality of mental health services, but they may have indicated an overall disregard for any benefits provided by mental health services. Yet, when considering the ATSPPHI mean (33.04), the possibility of that type of disregard from the total seemed less likely to explain respondents' perceptions.

An evaluation comparing the office of primary responsibility and the second barrier value indicated how respondents' perceptions of each helping source related to their attitudes toward the quantity and quality of mental health services. When each helping source was assessed across both values of the office of primary responsibility, significant differences were found in respondents' ratings of talking to commanders or 1st sergeants ($p = .019$) and medical doctors ($p = .038$). More respondents with perceptions regarding those sources disagreed that the availability of USAF helping services could assist them with problems. This finding seemed to

indicate that two particular types of sources in the availability of USAF helping services presented barriers to seeking help. Again, an unknown aspect of this finding was whether respondents believed that there simply was not enough of the indicated types of help available or that of the two types of help these were not regarded as helpful. The second question of the office of primary responsibility questions also helped answer this possibility.

No significant differences were found when respondents' second barrier scores were compared with whether or not mental health professionals inflate problems. Here again, respondents may not have perceived barriers to service because of the quality of mental health services, but in this comparison, they may be indicating that helping sources other than mental health posed greater barriers. This finding may have been congruent when the ATSPPHI mean was compared to the second barrier score. Problem inflation may be attributed more to the two identified sources, whereas sample respondents may still have had an overall favorable attitude towards helping services. Later analysis of possible differences between these responses separated by the criterion variable may provide an understanding of this finding.

An analysis comparing all respondents' degree of help utilization and favorable attitudes indicated whether or not their positive views of help-seeking related to the circumstances in which help was sought. When the ATSPPHI scores were assessed across scores of questions about help utilization, no significance was found. This finding suggests that all respondents did not differ in scores regarding

perceptions of feeling coerced into services, had seriously considered seeking USAF mental health help, or had sought civilian help. This finding indicates congruence between favorable attitudes and help utilization or that respondents had not perceived that seeking help presented barriers to seeking services.

When the ATSPPHI scores were assessed by a *t* test across scores of voluntary help-seeking, significance was found ($p = .002$). Table 17 shows that all respondents differed in means regarding their perceptions of voluntarily seeking mental health services. Members responding "yes" had higher favorable attitudes toward services and those responding "no" had means that were closer to Stone's (1998) findings. The findings in the present study indicated that there were differences between favorable attitudes and help utilization or that of all respondents who never sought help voluntarily perceived that doing so presented barriers to ever seeking help. This finding may suggest that favorable attitudes increase with service familiarity, but without using services, already negative attitudes remained.

Table 17

t Test of Voluntary Help-seeking Scores by MATS Combined Group Members

Scores		N	$\overline{X}$	SD
ATSPPHI	Yes	14	36.43	6.29
	No	10	28.30	4.83

With regard to evaluating all respondents' degree of help utilization across either barrier value, no differences were found. Mean scores from both barrier values (the sum of questions comprising each barrier type) also indicated that all scores were lower than the 12.5-point cutoff, the level indicating that respondents believed a particular source or career threat was a factor. The results indicated that the sampled respondents' favorable attitudes toward seeking services did not differ in their scores under the given circumstances. This finding might suggest that when seeking services on their own, by referral, or through civilian providers, respondents shared similar perceptions and attitudes.

MATS Survey and Criterion Variable Relatedness

The second part of the MATS analysis compared the four categories of help-seeking to the attitudes and perceptions among the members with or without stepfamily and divorce conditions. This type of analysis has not been conducted in any studies; thus, the information could not be compared to previous research such as that from Fischer and Farina (1995) and Stone (1998). These characteristics helped define service barriers by providers and members in treatment.

A comparison of the attitudes and perceptions toward seeking mental health services between USAF members with stepfamily and divorce conditions and USAF members without stepfamily and divorce conditions was conducted. Observations indicated that stepfamily and divorce members had a lower ATSPPHI score of positive attitude than did nonstepfamily and no-divorce members. As seen in Table 18, the ATSPPHI score sample of nonstepfamily and no-divorce members

Table 18

Favorable Attitude Scores by Members' Family Type

Scores		N	$\overline{X}$	SD
ATSPPHI	Yes	14	31.29	6.78
	No	10	35.50	6.74

($\overline{X}$ = 35.5) indicated a greater favorable attitude than stepfamily and divorce members ($\overline{X}$= 31.3). However, the difference was not significant, suggesting that these treatment members held more positive attitudes and perceptions of their experiences than other general members held.

An evaluation comparing respondents' views with and without stepfamily and divorce conditions of career threats and favorable attitudes indicated how their positive views of help-seeking related to each threat scenario. When ATSPPHI scores of members with and without stepfamily and divorce conditions were assessed across values of the first barrier, a significant difference was found. A Friedman's test indicated significance from the five types of threats (p = .0005). A step-down analysis with a Kruskal-Wallis test found that while respondents did not differ in scores about whether or not they believed their careers were hurt (p = .98), significant differences were found in what they believed about problem confidentiality (p = .039), faith in skills (p = .010), embarrassment (p = .004), and weakness (p = .001). This result indicated dissimilarity between attitudes of career threats and stepfamily and divorce conditions; that is, those respondents

perceived that most of the given threats presented barriers to seeking services.

Further analysis of the four significant threat types indicated where these perceptions are fixed. Analysis of barrier one, question two, threat from confidentiality, indicated that respondents differed in rating chaplains as a career threat. The mean rank of stepfamily and divorce respondents was 14.64, whereas those without stepfamily and divorce conditions was 9.5, showing that stepfamily and divorce members perceived a greater threat from that source than from the four others. This result was supported by further analysis of the second barrier (source). Another Kruskal-Wallis analysis indicated that a significant difference was found between criterion conditions on the chaplain source ($p = .007$).

Examination of barrier one, question three, threat of competency, indicated that respondents differed in rating chaplains ($p = .011$) and commanders or 1st sergeants ($p = .030$) as a career threat. The mean rank of stepfamily and divorce respondents' ratings of chaplains was 15.3, whereas those of nonstepfamily and no divorce was 8.6. The mean rank of stepfamily and divorce respondents' ratings of commanders or 1st sergeants was 15.1, whereas those of nonstepfamily and no divorce was 8.9. This result was also supported by analyses from the second barrier (source).

Examination of barrier one, question four, threat of embarrassment, indicated that respondents differed in rating chaplains ($p = .002$), commanders or 1st sergeants ($p = .022$), medical doctors ($p = .04$), and friends ($p = .020$) as a career threat. The mean rank of stepfamily and divorce respondents' ratings of

chaplains was 15.7, whereas those of nonstepfamily and no divorce was 8.0. This result was also supported by analyses from the second barrier (source). The mean rank of stepfamily and divorce respondents' ratings of commanders or 1st sergeants was 15.1, whereas those of nonstepfamily and no divorce was 8.9. The mean rank of stepfamily and divorce respondents' ratings of medical doctors was 15.7, whereas those of nonstepfamily and no divorce was 8.0. The mean rank of stepfamily and divorce respondents' ratings of friends was 14.6, whereas those of nonstepfamily and no divorce was 9.5. Many stepfamily and divorce respondents indicated their own embarrassment as a barrier to seeking services more than nonstepfamily and no-divorce respondents. These findings suggest that the source might matter less in attitudes of embarrassment than in the members' perceptions of seeking help.

The examination of barrier one, question five, threat of weakness, indicated that respondents differed in ratings of chaplains ($p = .003$), mental health ($p = .008$), commanders or 1st sergeants ($p = .025$), and medical doctors ($p = .004$) as a career threat. The mean rank of stepfamily and divorce respondents' ratings of chaplains was 15.7, whereas those of nonstepfamily and no divorce was 7.9. This result was also supported by analyses from the second barrier (source). The mean rank of stepfamily and divorce respondents' ratings of mental health was 15.6, whereas those of nonstepfamily and no divorce was 8.1. The mean rank of stepfamily and divorce respondents' ratings of commanders or 1st sergeants was 15.1, whereas those of nonstepfamily and no divorce was 8.9. The mean rank of

stepfamily and divorce respondents' ratings of medical doctors was 15.7, whereas those of nonstepfamily and no divorce was 8.1. Many stepfamily and divorce respondents indicated that their own weakness was a barrier to seeking services more than were found in nonstepfamily and no-divorce respondents. These findings suggest that the source might matter less in attitudes of weakness than in the members' perceptions of seeking help.

When analyzing members with and without stepfamily and divorce conditions across scores of mental health availability and problem inflation, no significant differences were found between the groups. Frequencies of both groups were evenly distributed, suggesting that nearly as many respondents believed mental health services were available as did not and that nearly as many believed mental health services inflated problems as did not.

With regard to examinations of the types of members across scores of seeking help voluntarily, by coercion, had contemplated, or through civilians, no significant differences were found between groups. Frequencies of both groups were evenly distributed, suggesting that nearly as many respondents voluntarily sought services as did not, nearly as many felt coerced as did not, and most respondents (83%) had not sought civilian services. Again, as in Stone's (1998) analysis, that contemplator variable in this study was difficult to analyze because of poor construction.

Members' written responses offered additional information about their perceptions and barriers toward seeking help. There were 5 written responses in

the comments section of the 24 returned surveys. Four of the 5 responses were from members with stepfamily and divorce conditions, whereas 1 response was from a member with nonstepfamily and no-divorce conditions. One other respondent provided additional comments in another comments block on the MATS; thus, there were 6 discrete responses. Four responses directly concerned the services that the respondents were involved in at the time their survey was completed. Two surveys directly concerned the confidentiality issue.

The responses regarding the confidentiality issue came from two members with stepfamily and divorce conditions. One member responded:

> Chaplains are the only ones a military person can talk to regarding problems and not have the chance of negative career implications, oh, and the ADC [Area Defense Council, a legal office at each air force base] if they are representing you.

The other member's response was:

> An off-base person is totally confidential and does not or will not affect your career. I am willing to seek help when I need it but am very hesitant to use military programs because my career is so important to me.

This person also responded, "I have utilized almost all programs offered by the A.F. [air force] but have always been more comfortable going to counseling with a civilian; you get what you pay for. This goes for my children also."

While these comments concern confidentiality, the respondents also spoke about how and where they seek help in relation to the issue of confidentiality. These members indicated a connection between the influences of confidentiality on their choices of services. The first respondent suggested that religious or legal

offices provide the most trust. The second respondent reported a belief that emphasized his priority on career protection and viewed help-seeking as a threat if help is not accessed with the greatest confidence protection available. From the scenarios posed by the MATS for members, these respondents provided their own perceptions of the interrelatedness of confidentiality and career threat. The impact of their attitudes toward barriers may indicate how help-seeking influenced their involvement in the alcohol treatment program.

The other three respondents addressed the last two sections of the MATS: (a) the office of primary responsibility and (b) utilization. One respondent, who did not have stepfamily and divorce conditions, had the following to say about being forced or coerced into talking with a mental health professional: "Substance abuse and mental health are two different things, but [I] answered as the same." Similarly, a respondent with stepfamily and divorce conditions replied, "I command directed [and] see counseling with my consent." The last respondent with stepfamily and divorce conditions in response to the issue of problem inflation commented, "Answer applies only to the [officer] that is running this program—other counselors are fine." The first respondent's comments addressed an interpretation of the MATS structure in the context of his own treatment program. Apparently, this person saw a greater need to express how the survey qualified his answers rather than the quality of his contact with the services being provided. The second respondent indicated that the reason for his treatment presence was external, perceiving that the clearest explanation for his answers was

to direct attention on the official action requiring his participation, not his own behavior regarding alcohol use. Although exact details cannot be determined from the third respondent's comment, it appears critical of the treatment director's clinical or administrative skills. However, in reality, the comment may have reflected a typical patient's view of the confrontive nature of the treatment model (Daley, 1999). Overall, as the survey section on utilization asked, respondents' perceptions focused on the level of their own involvement, which established that their answers were not hypothetical but stemmed from personal experience.

Focus Group Interviews

The second part of the last research question addressed the personal beliefs, perceptions, and attitudes of the focus group participants. These participants detailed their experiences behind the views of barriers in relation to their own family conditions. Overall, stepfamily and divorced members indicated beliefs regarding how they felt compromised in their occupations, helping sources, and stepfamilies regarding authority, privacy, and group cohesion. Overall, nonstepfamily and no-divorced members indicated beliefs regarding self-disappointment as well as general satisfaction of services. Both types of members indicated that they were concerned about threats to their occupational image, that the length of treatment was too long and inflexible but that in hindsight treatment was valid, and that special needs are not considered in clinical treatment. Table 19 offers a summarized verification of the findings regarding themes interpreted from the views of the combined types of members as they relate to the primary

Table 19

Members' Primary Beliefs Related to Main Stakeholders

	Stakeholders			
Themes	Unit	Helping service	Family	Self
		Awareness		
-Stepfamilies' needs -Alcohol treatment	-Embarrassment to home and work -Fear of career damage -Fight harder at work for less recognition -More of a burden and less socially active with previous peers	-Particular needs unaddressed -"One treatment fits all" unacceptable -USAF providers less expert than civilian helpers	-Reduced cohesion and less trust -Increased stress and stressors -Ripple effects in spouse's and family's activities	-No belief of differences in family type, yet report more stress in stepfamily -Treatment is valid but should be individually tailored
		Appearance		
-Image -Work record	-Permanent negative record -Not perfect -Not contributing -Threatens leader role -Misinterpreted by command	-Power to influence discharge is permanently damaging -Misinterpreted thoughts and actions by treatment providers	-Less respect and less regard from stepmembers -Distortion of events increases family conflict -More explaining and defending	
		Autonomy		
-Privacy -Authority -Capability	-Knowledge of incident is intrusive because of USAF "team" concept -Subordinates less compliant -Support from peers, supervisors, and command	-Increased risks to family because of inflexible program -Increased risks because of miscommunication, uncoordinated care	-Childrearing authority eroded -Support from rehabilitated or "clean" parents	-Assumes primary responsibility for welfare of stepfamily -Maintains rights to use alcohol at discretion

stakeholders.

The single main theme interpreted from the compilation of the three subresearch questions addressed the knowledge level of members with stepfamily and divorce conditions across both types of members or in both interview groups. The findings from the interviews indicated that these members were not sufficiently aware of the challenges that are a part of their family organizations, which require increased helping services and education. Grouping participants' reports into themes that captured the common thread supported this finding. The three themes were given labels that summarized participants' experiences. These labels were: (a) appearance, (b) autonomy, and (c) awareness. An explanation of each theme is provided in the following sections.

The theme appearance concerned members' beliefs with regard to internal and external sources. Those sources are persons found in occupational, service provision, or personal areas. These persons were expressed as peers at work, supervisors, commanders, helping providers (on and off base), spouses, and stepmembers or nonstepmembers of their own families. Members most often expressed their ideas of the impact of the alcohol treatment through implications of the critical role image played in their duty position and performance.

The theme autonomy concerned members' beliefs toward their ascribed power as credible persons in control of their lives. Members' perceptions focused on their roles as family heads, capable workers meeting all command expectations, or persons (entitled to) maintaining an absolute separation between work and home.

The theme awareness concerned members' beliefs toward their acquired level of knowledge about their circumstances since treatment. Members' views

attended to the aspects of their stepfamily's (or nonstepfamily's) needs, sensing increased stress, alcohol service provision, and reflection of their entire involvement.

Each of the three themes was examined across the interface with each stakeholder. The four stakeholders were defined as the unit, helping service, family, and self. The unit represented the members' work sites and reflects the functional activities of the members, their associates, and command structures. The helping services represented military and civilian service providers, which were mental health specialists or religious counselors. Family stakeholders were spouses, stepchildren or nonstepchildren, and stepparents or nonstepparents. The self represented the members' interpretations of the impact of their behaviors in areas of their lives. The concept of self is inherently inseparable from this thematic analysis because the interface with each stakeholder necessarily states the members' beliefs. However, the concept was formed separately to extract any opinions found reflecting a deeper level of self-understanding. Table 20 provides a summary of members' attributions across each of the three subresearch questions.

Subresearch Question 1

What do you see as barriers to USAF substance abuse clinic services?

Members with stepfamily and divorce conditions. Members with stepfamily and divorce conditions expressed a general lack of faith in their employer and their families. Members' beliefs mostly regarded a lack of support from their unit command, service providers, and stepfamily members. The main theme interpreted

Table 20

Attributions of Barriers by Types of Members

Type of member	Subresearch Question 1	Subresearch Question 2	Subresearch Question 3
Stepfamily and divorce conditions	EXTERNAL Uncontrolled arbitrary information exchange	EXTERNAL Dissatisfied with provider-type deficits	INTERNAL Unable to help stepfamily members because of program design
Nonstepfamily and no-divorce conditions	INTERNAL Reduced work contribution	INTERNAL Incongruence with parents' history	EXTERNAL Generalizing intact members' uniqueness

from members was their anxiety related to high probabilities of an uncontrolled spread of misinformation regarding the circumstances of their alcohol incidents to an overly directive system with a selectively low threshold for errors. Thus, members viewed the lack of general support as an increased threat towards their efforts to succeed at home and at work. Members' statements indicated that their views about less support were not so much that the other concerned interests had been withdrawn, but more that once activated secondary to the incident the collective responses become oppositional and automatically damaging to their personal interests. The barrier, then, was the threat that the arbitrariness attributed to higher authorities' flow and exchange of information surrounding the members' behaviors once the incident occurred had compromised the members' status in the military as well as their families. This belief reflected mostly external processes, as

seen in the following reflections regarding official responses.

The members more often believed that the incident was a threat when commanders and their staff members were directly involved in the members' treatment programs. One male said:

> I think one of the biggest barriers is . . . that information is communicated to the command structure that you work for . . . in a sense that it could be transmitted in . . . whatever media, whether it is written . . . a telephone call, . . . friends, or maybe just a basic misunderstanding of a mental health or substance abuse employee that just doesn't understand the privacy act.

Another male said:

> I know commanders . . . can look at your file here, these files. What's to stop them from looking through and looking at notes. . . . If I was . . . having problems with my wife because of what has happened, it may not be something he needs to know.

A female said:

> The way your counselor perceives you, that's how your commander's going to perceive you also because your counselor doesn't think that you're fitting in or in group you're not discussing. . . . Your commander's going to see that and think, "Oh well, she's not trying—he's not trying."

Finally, another male said, "I think they truly have confidentiality problems. They sit down, and they have meetings with my commander, my 1st sergeant, my supervisor, there's not much confidentiality there." The reactions indicated beliefs that the parties with privileges to know details about their incidents did not routinely exercise discretion in accordance with the privacy act, could very likely be communicated subjectively, and could reveal intimate marital information.

Members without stepfamily and divorce conditions. Members without stepfamily and divorce conditions expressed beliefs that indicated support from their unit commands, service providers, and families. The main theme, though, focused more on self-disappointment regarding their own behavior because of the impact to their peers within the duty section and to their family members at home.

The barrier, then, was the members' concern that their ability to effect a substantial work contribution had been compromised by their own inappropriate behaviors. This belief reflected more of an internal rather than an external attribution, as seen in the following personal reflections.

The members more often believed that their own inappropriate behaviors created barriers toward accessing services. One female said:

> Embarrassment, fear of friends, family . . . don't want anybody to know that they are in the substance abuse program . . . don't want people to think they are irresponsible, . . . but nobody ever wants to admit that . . . they have a weakness that other people can use to, not so much you know as someone could use to exploit you, but they may treat you differently because of it.

Another female said:

> I agree, I was the same way. When I first started this program, I was really embarrassed to tell anybody. I didn't want anybody to know, it was sort of a hush-hush sort of thing, nobody knew what appointment I was going to, they just knew I disappeared for a few hours every Thursday, . . . but now I walk around the hallway because I teach students as well, and you know it's kind of hard to like be teaching somebody and have them look at you and feel like you're not so perfect, I'm not going to listen to you, that sort of thing, and it took me a while to get used to that. . . . Although when I start to think back in my mind, I also start to think that you know that they don't have to fight as hard to do the things that we do, they don't have to fight as hard to be in a normal environment and to relate to our friends, and to not drink and to not do the things

> that we were doing before, so to me, I mean, thinking that, you know, we have it easy, but just know in your mind you don't. . . .

Finally, a male said:

> Yeah, in the military, both my military and my civilian supervisor, they're supportive, 'cause they . . . both . . . had alcoholic problems. . . . Still . . . you don't ever get over it, and my civilian, his wife has alcoholic problems, so they kind of relate to it, and my 1st sergeant is really cool with it. . . . I haven't had a crew leader even though I'm the lowest ranking person. I've still got troops appointed under me, you know, and they don't, I can see a slack in them since I came back, you know, where I have to go here, they don't outrank me, so they don't see me as much of a, I don't want to say authority figure that's a supervisor, so I kinda catch not much heat from them, but they don't do what they used to do you know, when I needed it done. . . . It's something you put up with every day. Ya know, I don't work any less than anyone else. If anything else since I've gotten an "atta[boy]," I try to make it my personal thing to catch up, I work harder to catch up on the work that I missed for 3 weeks. I work hard. You know there's times I do flight control every weekend; ya know when there's rain, I'm out there pumping. I put in over, so-called overtime I guess you'd call it, ya know. Ya don't ever get overtime, but I'm out there every weekend. I pulled, I supposed to pull standby once every 6 months. Well, I'm pulling it three times every 6 months, and people don't really pick up on it. I don't do it, ya know, it's not like my supervisors are doing it for extra duty or anything. I volunteer for it. I feel like I left them with a burden, ya know for 3 weeks, and they don't see it 'cause they're into a lot of things. I've got some support—my wife and friends, but just that on the job I have like four people I can relate with at work now out of 40 . . . people I used to. . . .

The reactions indicated beliefs that, although support appeared open and nonjudgmental, their capability had been called into question through their own actions.

Subresearch Question 2

How much easier or more difficult do you believe such services are to accept because of being part of a stepfamily (nonstepfamily)?

Members with stepfamily and divorce conditions. Members with stepfamily and divorce conditions expressed views that the unique needs of each member's individual situation, regardless of family type, be incorporated into treatment. The barrier connected to recommendations for improvement was that the lengthy time and complex protocols required by treatment compromised their ability to control how their stepfamily members received any medical services needed in relation to their family type. Although elements of external reactions are apparent, this belief seemed to reflect a prominent internal attribution, as seen in the next responses. One male said:

> Six months . . . 2 or 3 months of rigid treatment like twice a week, 8 times a month for the next 3 months, you could say that's long enough to find out what is wrong with you, but going through 6 extendable to 9, could be a year, I think, I mean there's a time and point where you come off or your career will be destroyed. . . . I think they need to consider each and every individual, everybody has a different story, everybody's got a different situation and they need to consider that when they say, "You gotta do this two times a week at this time, you gotta do this five times a. . . ." But they have to consider the fact that . . . with stepfamilies and two parents working and you've got child issues, . . . they should be able to tailor it a little better.

Another male said:

> If they have a problem, they want to go downtown 'cause they feel uncomfortable about what goes on here . . . that closeness or that confidence in my stepchildren is compromised because they know this isn't an accredited type program. . . . In my case, . . . a little over a year ago my stepdaughter was using the services in mental

> health and her primary care manager . . . had switched her out from flight medicine to family practice, then was referred down to mental health, and she had an incident . . . where there was a variety of medicines that were prescribed to her, even though a lot of things are on the computer at the same time and they check those kind of things, she had an incident where she ended up overdosing on medicines that were prescribed to her and she was at the same time . . . she had to have a root canal done with her dental which was prescribing other types of medicine. . . . So this was the type of person that had never taken any kind of drugs but with the medicines that were prescribed downtown conflicted with what was going on over here and she had this huge incident that, I mean, they ended up pumping her stomach. . . . The police were called, . . . but I felt after the incident was done, and this was an all-night deal because we thought that maybe she was, overdid what she was taking and misused the drugs that were given to her or that there was a larger concern of possibly a suicide because she was going through a state of some depression at the time, this was something as a stepfather, I didn't . . . know . . . completely, there's a certain level of confidentiality that goes on with the kids when they get that old, but I thought that a, I couldn't understand how mental health was providing a particular service, but yet you got this stepchild that has just gone off the deep end and could have possibly died that night. . . . I have a lot of questions. . . . "What is going on between family practice, mental health, and at the time she was also seeing a person down here in substance abuse?" . . . And so that was my issue, was how are these three organizations communicating with each other and the decision that I had come to was I believed that they weren't because we would not have a child in a hospital getting her stomach pumped . . . being monitored, . . . and as I got into a little bit of my own sorta detective of what was going on, at the same time I noticed that . . . she was having a relationship with one of the physician assistants that were . . . providing a service here, a younger person, so that really got my gander.

Another male said:

> Well, with my family, I have two stepdaughters, and even though I am their father figure, I'm really not their father, I can't be, I love them like they were my own kids, but they're not my own kids, not mine. I have less of a say, so I think, in their everyday life decisions, their mother does because of that situation. I support them 100%, I don't have 100% say-so. It's a different interaction I think than in a bloodline family, and things get kinda touchy when you're,

> when you want to be in control, but you have to be able to realize that there is a difference there. And it weighs out the difference, it's kinda hard for me to put into words, you draw a fine line, everything is in moderation, and you have to equalize your balance and control with your being, understanding, and what-have-ya. It's not easy raising children, and you're under a lot of stress in a stepfamily, I think more so. I have children from, that are my own kids from my previous marriage, and even though they don't live with me, it's much easier with them than it is with my stepchildren.

Finally, a female said:

> Having come here 6 months, it's killing me, actually it is impossible. I have to come in here twice a week . . . every Thursday and another earlier in the week to meet with my counselor. That puts me out big-time at work because I have all these appointments during the week and then substance abuse so, that is, it's killing me.

Their reactions indicated beliefs that emphasize an inherent inflexibility regarding the allotted time per week, the duration of program length, the frustration in staying informed on what type and how many services are applied, and their ability to authorize or exercise parental discretion in approving those various services.

Members without stepfamily and divorce conditions. Members without stepfamily divorce conditions expressed beliefs that indicated few recommendations for substantive changes in treatment, other than taking care not to lump their own family types into the stepfamily model when members have histories of parental conflict. The barrier associated with recommended improvements was a generalization of how members' characteristics and needs are perceived by treatment providers in the military, which would compromise their own unique attributes of an intact family history. This belief reflected more of an external attribution of system deficits, as seen in the following reflections about services.

One female said:

> I think the program is, I think it is pretty good. I mean, I think it has given us a very clear understanding ya know, what we are doing to ourselves, what exactly an alcoholic is—a disease ya know and that people don't, people don't . . . ya know, whatever, it's hereditary, why go and drink. Ya know, I think it gives us a very clear understanding of that. . . . You know people look at my parents . . . it was 2 years ago when my parents got arrested and they went to rehab and I had walked in there, there's a big long story, my mom ran off, my dad's still there, my mom finally called me, so I took her there and everything and got her inside and the lady, the nurse at the station there, she turns to me, "Is that your mother?" "Yeah." She's like, "Oh, is that your stepdad?" "No, that's my dad." "You mean these are your parents and they are still married?" "And I'm like yeah, for like 19 years ya know." And she said, "That's very unusual." "I'm like okay, thank you, whatever."

A male said:

> I thought I would be, ya know, criticized the whole 3 weeks. Ya know, like, "How dare you? . . ." As far as the class here, it opened my eyes wide open. I came in here ya know, I don't need to be here, I don't think I should be here, okay I had two slipups in the last 3 months, ya know, I'm a kid, right? Ya come in there . . . I'm invincible. . . . After that 1st week, I was like a little bit smarter ya know, but I still think I shouldn't be here. Then I went into the next 2, once I was in the 3rd I was screaming at the top of the mountains. . . . I think the counselors here are really good because they're not afraid to, ya know, get really intense one on one, to find out exactly what is going on with you, what you want and what you need. They tell you what you are, really. I mean, they're not afraid to tell you that's your problem and they really, really push you to work on everything. They don't want you to brush something off, a conflict or anything. And it's really good though 'cause they do make you think, they do make you work, and they do make you realize you do have a problem.

Finally, a female said:

> I would have to say the program went really well. I mean, it's really well thought out, I mean you do group activities. Even if your family, your home life doesn't relate to somebody else, the very fact that you're an alcoholic is such a great basis to talk about. Like ya

> know, we talked to other people out there, and we're just good friends with everybody that it doesn't mean your family life is so completely like yours. We actually did role-playing in the 3rd week, which was really rough. We role-played and basically it is who you had . . . the greatest conflict with.

Subresearch Question 3

How can these services be improved to better meet your needs as a stepfamily (nonstepfamily)?

Members with stepfamily and divorce conditions. Members with stepfamily and divorce conditions expressed that they realized the special needs of their internal family processes, yet believed that the service providers did not have an understanding or include much of that knowledge in services delivered. As a result of that occurrence, these members' relationships and efforts to maintain a cohesive positive family climate were not fully appreciated, did not receive helpful information, and continued to feel stressed in the family and on the job. The barrier indicated by members' beliefs was that the disparities between the types of service providers compromised their efforts to lead their work areas and stepfamilies. This belief reflected more of an emphasis on external attributions, as seen in the following reflections.

The members more often believed there was difficulty in getting services when providers were chaplains and mental health or substance abuse providers. One male said:

> I don't think our substance abuse or mental health folks in the military complex are as knowledgeable than what services are available downtown. There's just simply that corporate knowledge

> and the turnover and, . . . I think there's only one accredited person down here that is able to do substance abuse. . . . How do you know that this is actually a valid treatment for your kids or for your family structure or your military complex? . . . I tried to explain this . . . to my squadron commander and some of the disappointment I had in the services here; it eventually led to her going downtown to seek, ya know, treatment from a mental health provider down there and eventually over a month's time they weaned her off the three or four medications that they had prescribed and um, she's actually doing pretty well right now. She hasn't had, hadn't had an incident since March so, but again I think, and my wife's very disappointed in the professional level of services that were being provided. My wife obviously knows her daughter a lot more, but that was something as a new parent coming in, I was really concerned. . . . I was appalled at the miscommunication at family practice, mental health, and substance abuse. . . .

Another male said:

> I think you hit it on the head when you said corporate knowledge. They don't have it, it's out of a book and everybody's treated as A, B, C, D. . . . You don't trust the air force chaplain. . . . I saw my local chaplain. I don't even trust the military chaplain. . . . I know for sure that my priest downtown is bound to confidentiality. I have seen certain things in my 20-year military that even a Catholic priest, he's a colonel and I'm not too sure he's keeping with his vows because of his wearing a uniform and his pressure from others, so it's not a matter of being anonymous. I have certain rights, so if I can't get them from the military, I'm gonna go to where I know I can get them.

Another male said:

> I just don't get the quality chaplain service out of the military than what I do from my own Lutheran pastor or church that I go to. I want Missouri-scented Lutheran stuff, and if I go to the chaplain service here to the Protestant, I get a watered-down version of it and my wife's the same way.

Finally, another male said:

> When it comes to volunteering to come, it wouldn't have made a difference whether it was a regular marriage or a step for me, because again it's always been, ya know, from day one I've been in,

> you don't go to these people, and the thing is I've seen people who have gone . . . and it hurt them.

The reactions indicated beliefs that the difficulty in getting services was attributed to the providers directly responsible for the care available at the first and cost-effective level.

Members without stepfamily and divorce conditions. Members without stepfamily and divorce conditions expressed beliefs indicating less of a focus on whether or not family processes were included in treatment and more on how their parents' own substance abuse, marital conflict, yet intact marriage histories formed a closer parent-child bond realized while in treatment. The barrier represented by these members' views was their rationalization of how noncontributory their family-of-origin experiences were regarding the level and pervasiveness of their parents' substance intake and the degree of marital conflict. The result of this belief stemmed from information revealed through treatment. This belief reflected more of an internal attribution as seen in the following responses. One female said:

> I don't think I am here as a direct result of . . . my parents fighting or anything like that. . . . Nobody's home life is normal, . . . and I honestly . . . don't think I am an alcoholic today because of how my parents acted. I think I'm an alcoholic today because (1) it's hereditary, definitely, (2) because that's just who I am, it's in my mind to be an alcoholic, that's just me. . . . Yeah, there's outside contributing factors but not anything that would make me want to drink. . . . I didn't drink to forget stuff, . . . I drink because I wanted to get drunk. . . . My family was probably just . . . fine, . . . but I tried . . . to do the blaming it on my mother thing because, like I said, she was on antidepressants, so growing up she was a little bit off sometimes, but most of the time we had a pretty normal . . . okay type relationship. . . . My mother is a recovering alcoholic for 15 years. . . . She's been sober. . . . My grandmother's an alcoholic . . . my aunt on my mother's side . . .

> my uncle on my mother's side a recovering alcoholic and addict. This seems to run in the family. . . . My parents have always gotten along, but they haven't always been happy. . . . My home life was a little bit different. . . . Things could get a little rocky around the house . . . some yelling and screaming. . . . But my parents love each other, they are closer now today. I mean I can't really relate to the whole fighting and drinking thing because they stopped drinking, my mother stopped drinking when I was really young. So, I've kinda grown up seeing them be closer, closer because of it. They started I guess, their healing ya know, earlier on. . . . When I grew up, my mother told me that if I ever wanted to drink I could come to her and I didn't really want to, so I used to sneak it. I used to sneak it behind their backs all the time, sneak out and drink and that type of thing, then sneak back in. She wasn't stupid, she probably knew, but she'd pretend she didn't know so she wasn't at all shocked when I called her one day and said, "Mom, guess what, I'm in a substance abuse program." Ya know, she was shocked, but she wasn't shocked at the same time. It was also something that she didn't want to come out and ask, ya know, how much are you drinking, but then when I said it, she was more comfortable talking to me about my treatment and stuff.

A male said:

> . . . with my family every week. . . . I give um a call. . . . They all know what . . . I'm going through and . . . they're all for it, they support me 100%. . . . I have a younger brother . . . who has criminal charges pending on him because of alcohol. . . . What I've learned here can actually help other people. . . . I'm not trying to counsel him or anything, just telling him things about alcoholism and stuff like that. My parents are 100% behind him. . . . There were alcoholics, my aunts, both my mother's side, my dad's side was not as bad. It really wasn't something that was talked about when I was growing up. My parents actually gave my permission to drink when I was 17. As long as ya know, get brought home by the cops, they say that I could drink in front of them. There was really nothing that was ever brought up about it, we never really talked about it . . . until I now. . . . It's lots easier to talk, ya know back home it would've never been mentioned. They would have never told me I had an alcohol problem, I mean somebody trained would have to point it out to you. You just didn't speak of it, ya know. It's not like something that was forbidden to say. . . . There'd be parties, they'd fight. . . . It probably started when I was 15, I'd come home, ya know, every time they'd drink, something'd get said about

> something previous and all of a sudden there'd be this huge fight, this huge argument. . . . I don't know, she would always threaten to go to the cops, ya know, makes it elevate so much quicker. And I'd come home, my mom, I don't know, I guess, knocked my dad out a couple times. My dad went to hit her and I jumped in the way and I ended up getting hit. From there on it stopped, but before that, man, they'd fight. Something would get broke, like every month something else would get broke or busted. Ya know they'd, mom would split for a day or two or pop would split for a day or two. Like that for a while before we moved, that's when we lived in DC. Um, I think when we moved to Maine and we had, a, my youngest brother, I think things started slowing down a little bit. . . . I conflict with my wife a lot.

Finally, another female said:

> It was just one of those things, 'cause I know where I grew up it's small . . . Catholic community, big families, I was 14, I was in eighth grade actually, and my mom would buy me alcohol. I would go to town, my freshman year, every day of high school, we would drive into town, meet everybody, have a case of beer in the back. . . . My grandfather owned a gas station, and he sold beer, and he'd just give it to ya. . . . Both my parents . . . have been together for 20 years, but I wouldn't call my parents traditional by any means. My mom, she will actually be clean for 2 years this Monday so I know, my mom she always talks to me about it. She's behind me all the way, so's my dad. My dad was an addict. . . . In my family, it is kinda an acceptable thing, you're not looked at like something is wrong with you, ya know, whatever. As far as my family being close together, ... I've never been closer to my parents since they started rehab. It's brought me closer . . . than ever.

The reactions indicated beliefs that their parents' conflict, extensive family substance use, and permissiveness in obtaining alcohol had not directly contributed to their behaviors that lead toward the referral incidents.

A final dialogue seemed to identify a common belief members shared about their experiences:

Female 1: A lot of people, I don't know, I think a lot of people whenever they think of . . . ya know, my parents were married, my parents were heroin addicts, and my mom was alcoholic, most people I would think would think . . . your parents aren't married.

Female 2: Right, they're divorced.

Female 1: They're divorced. Yeah, they would think they weren't together, maybe they were never together, maybe they were never married. That's how they perceive it.

Female 2: Yeah, I think that's how people perceive a lot of things like that about families.

Female 1: Yeah.

Female 2: Especially because my mother was an alcoholic, people naturally assume my mother and my father aren't still married, they've been married for 22 years now.

Female 1: And that your father is your stepfather.

Female 2: Right, ya know because, ya know, it's almost like this preconceived notion that they can't have a problem like that and work through it. Which almost kinda slides over into whether or not you have a relationship with somebody now. Me and my husband, I find us going through the same thing as I found my parents going through, now that I'm recovering, ya know, it's sort of the same thing—preconceived notions there.

These reactions indicated beliefs that current service delivery was effective for rehabilitation, but any improvements that included reversed stereotyped views would be unsatisfactory. Their views seemed to maintain a notion of the uniqueness within each patient's traditional family circumstances.

CHAPTER 5

DISCUSSION

From the findings, evidence supports the conclusion that the impact of stepfamily and divorce conditions among USAF members is pervasive and poses substantial obstacles for alcohol treatment providers. This section summarizes and discusses the key findings in relation to the theoretical frameworks identified previously. Recommendations for improving awareness of the impact of stepfamily and divorce conditions on members are submitted. Finally, limitations associated with the findings and recommendations for future study are suggested.

Summary of Key Findings

As discussed in the literature review, persons with stepfamily and divorce conditions experience greater social hardships in maintaining family cohesion and personal stability. The review indicated a general lack of familiarity by service providers of the specific needs associated with stepfamily and divorce members. The review proposed that unintentional, yet inherent USAF service design and delivery flaws formed barriers supporting social myths and stigma regarding divorced and steppersons' circumstances. Findings from this investigation provided evidence that many members currently with stepfamily and divorce conditions represent the potential that more members are likely to assume stepfamily and

divorce conditions. The evidence indicated that many members bring such family circumstances with them to their USAF occupations, yet fail to successfully attend and resolve accompanying challenges whether by their own actions or those of the USAF treatment community.

Research Question 1 examined the number of members with stepfamily and divorce conditions during 1 year within three substance abuse clinics. Results showed that members with stepfamily and divorce conditions in alcohol treatment programs at each base comprised two thirds of that outpatient population seen in 1 year. This finding was compared to a previously completed pilot study of the same subject matter with exactly the same findings. This result suggested that certain member characteristics are more common than identified in general stepfamily research, yet apparently are less known to USAF service providers. The results also suggested that members shared family histories with different pathways toward alcohol abuse and treatment.

Research Question 2 examined demographic, career, and clinical characteristics within and between the three selected treatment sites. Results indicated that the most common type of members with stepfamily and divorce conditions were the youngest category of males, who had never married, who lived in base dormitories, and who had no children. As indicated from the findings, these members usually did not have their own stepfamilies but more often came from their parents' stepfamily and divorce arrangements. The most common type of members with stepfamily and divorce conditions had or were the lowest

ranking, held operational duties, served the least time, were newest to their base, and returned to duty after treatment. In addition, these members with stepfamily and divorce conditions had one alcohol incident, fewer appointments, no suicidal behaviors, no abusive pasts, and split between no diagnosis and having an alcohol diagnosis. The results suggested that these members' characteristics found at USAF base alcohol treatment programs are predominant.

Research Question 3 examined the equivalency of the three types of characteristics compared to the general USAF population. Most important to this study was the result that members were very similar in the distribution of the stepfamily and divorce conditions across the three research sections and the other two USAF middle organizational levels. The results provided a view of the extensiveness that the impact of these issues poses to members and medical service planners.

The results showed a greater representation of five characteristics in sample members than was found in members across the general USAF population. Compared to the general USAF population, members in this sample were more often male, younger, never married, enlisted, and had been on an assigned base less than 2 years. On the other hand, results showed that the sample had fewer members with children, more members in operational duties, and more members who had served less than 2 years. These findings were similar to distributions found in the survey group, the record review, Major Commands, and the sites. All of these results suggested that the members sampled represented an intensification

of already predominant characteristics found across the general USAF population.

Research Question 4 examined demographic, career, and clinical characteristic differences between the two types of members' family conditions. The results showed similarities in the demographic distributions of gender and age, career distributions of rank, time in service, time on station, and duty determination as well as clinical distributions of incident referrals, number of appointments, and suicidal history. However, differences were also found between the two types of members in the three categories of characteristics: (a) demographic distributions of single status, numbers without children, and residence; (b) career distributions of operational duty position; and (c) clinical distributions of histories of abuse as offenders or victims and more prevalent alcohol diagnoses. These results indicated that the members resembled each other substantially across the demographic, career, and clinical categories, but they were mainly different in their histories of violence and diagnostic outcomes. The results suggested that the members with stepfamily and divorce conditions in alcohol treatment represented a consistent pattern at base alcohol treatment programs.

Research Question 5 used the MATS instrument to examine the attitudes and beliefs held by members with stepfamily and divorce conditions that indicated barriers toward using USAF clinical services. The results of members' attitudes with stepfamily or divorce conditions were not as favorable toward USAF services as other members' attitudes. In addition, more barriers were perceived than for nonstepfamily and no-divorce condition members.

Research Question 5 also contained several subquestions beyond the design of the MATS instrument that asked members to specify their attitudes about barriers using USAF clinical services. The results showed that members' beliefs regarding barriers reflected MATS results of the same type of members' attitudes toward "career and source" threat barriers. The results further showed that members' beliefs regarding barriers were directed toward a widespread compromise of their integrity at work, in treatment, and with their stepfamily related to their authority, privacy, and group cohesion. These results suggested that the members believed they possessed less opportunity to direct their own course of life events or those of their stepfamilies.

Theoretical Analysis of Results

Two theoretical perspectives were applied in the production of this study: (a) the social constructivism framework and (b) the ecological model. Both theoretical frameworks provide a convergent approach towards better understanding the implications of members' characteristics for the USAF service community.

Social Constructivism Framework

Raising social consciousness towards social change requires that the power relationships expressed in language and worldviews work cooperatively to create new meanings. This reciprocal effort indicates a primary postmodernist component of social constructivism. As stated earlier, determining who composes the agreement between social theories of action and how those come about (Payne,

1997) stands as the essential premise when applying social constructionist views to problem causes.

In order to demonstrate their respect towards others, parties composing the agreement must adopt a reflexive perspective or the expressed relationship of mutual influence between ideas and social institutions. The result is a blend of diversity and complexity that permits the exchange of new meanings without the influence of traditionally dominant values and social expectations. Applying reflexive social work theory to members with serial divorce and stepfamily issues implicitly accepts knowledge apart from just observational and experiential evidence. The outcome emerges as an interpretive exchange regarding the social power of family organizations.

The implications that stem from this theory consider the construction of reality by decision makers in what is considered for decision, who is considered in decisions, and the attributes that justify the decisions. As found in the results of this investigation, there were many members with stepfamily and divorce conditions. Theoretically, the prevalence of those characteristics in members involved with alcohol programs could emerge from a lack of discourse between how the members are thought of and how they think of themselves. Their perceived social reality may be expressed in their traditional definition, believing and behaving as defined by those not of that group. As the stigmatized roles are unchanged in social consciousness, internal acceptance meets external expectations. If they are characterized as powerless, then they could express more powerlessness

when dealing with USAF authorities who are in command, medical providers, religious leaders, or peers.

The implication is supported by other findings from this study, as seen in the perceived barriers to treatment services that are evident in the members' beliefs. The survey and interview findings of the members' low regard for seeking help with alcohol abuse sooner could indicate that the reflexive theory is not part of the expressed relationships between the treatment services and the labor force of the USAF. From the members' perspectives, the relationship appears to represent the power holders more than reflexivity. Overall, members consistently chose not to make proposals to redefine new social meanings. Thus, the power-holding side of the relationship defines the terms as deficient, which may contribute towards and perpetuate views of stepfamily and divorced members.

Since there are many more members in treatment who have stepfamily and divorce conditions, the reason services could be underutilized or avoided indicates that these members may accept their problems as defined by others and do not see how circumstances would change if help was sought. As their beliefs about their problems are reflected by those who hold social power within the general USAF community, the socially acceptable method of managing such increased stress is the abuse of alcohol and the norm not to seek help.

Ecological Model

In order to explain the complexity of conflict and physical abuse in families, the ecological model emphasizes the role of cognitive processes, which

integrates systems theory, stress theory, social cognitive theory, and the coercion model (Adler-Baeder, 2001). The ecological model applies to the present study in connection with the finding regarding members' histories of abuse either as offenders or victims. Bearing in mind that generalizations could be premature, the possibility exists that there is a relationship between members' abusive histories and their inability to manage stress well within the increasingly fluid and demanding constraints of the USAF environment, remarriage, and stepfamily.

The social cognitive behavioral model focuses on interpersonal and dyadic psychology and processes, as related to the level of stress for individuals of maritally intact relationships as well as stepfamilies. Again, as Adler-Baeder (2001) stated:

> Some of the variables and relationships among variables are supported by findings in the general child abuse literature. Other factors included are unique to stepfamilies and are supported by evidence from studies of stepfamilies and conflictual stepparent-stepchild interactions. Included are a number of extrafamilial context variables and a number of intrafamilial context variables that potentially lead to parental stress. . . . The model suggests that high stress levels combined with the socio-cognitive coercive behavior process can lead to abuse. Cognitive processes of the parent and child act as a filter through which the environmental stimuli affect parent and child behaviors. Negative cognitions result in negative behaviors that further elicit negative cognitions and result in negative behaviors from the other individual, setting a coercive process in motion toward increasing levels of conflictual interactions. (p. 26)

The implications from this model for this study regard the reinforced negative thoughts of members with stepfamily and divorce conditions. These negative cognitions and subsequent behaviors would have occurred very early in their childhood from negative adult behaviors. Given the unseen nature of

cognitions, it is difficult to explain causality when applied to "conflictual reactions." Yet, members' characteristics may reflect the negative thinking spiral that effectively prevents them from breaking out of the cycle of negative reactivity.

Service providers could also unknowingly reflect pervasive negative thinking and attribute behavioral problems to outpatient members because of serial divorce and stepfamily stereotypes. Members could continue their habitualized negative thinking and behaving reactive pattern. Thus, such members may appear more often to the untrained clinician as resistive to treatment or oppositional to clinical authority. Depending upon a clinician's diagnostic skills, such members may be identified with alcohol problems more often than needed, although in accordance with DSM-IV criteria (American Psychiatric Association, 1994). This possibility is supported from the study finding that USAF members with stepfamily and divorce conditions are diagnosed more often with alcohol problems than are diagnosed without those family conditions.

The converse may also be possible; that is, members without the conditions may present as less resistive or oppositional and may be diagnosed less often with alcohol problems than members with stepfamily and divorce conditions. The resulting overall impact to USAF members with these conditions may be that their accumulations of alcohol incidents spark official actions that operate against their familial interests rather than their career interests. The accumulation of subsequent legal actions cannot be overcome before decreased support and discharges from duty occur. One possible negative outcome of that likelihood would be a greater

attrition of these personnel, which represent a large portion of the USAF population. Results from this study suggest that lower retention of such members cannot be ruled out. USAF social workers must advocate more strongly for a fuller understanding of members with stepfamily and divorce conditions in treatment for alcohol abuse to other military mental health practitioners.

Increasing Awareness of the Impact of Stepfamily and Divorce Conditions

Members with stepfamily and divorce conditions seem to have an inherent skepticism of authority, as that power represents the granting of resources that improve members' lives. If so, USAF treatment program planners and directors should reexamine their clinical protocols, treatment modalities, and therapeutic skills in order to maximize members' trust and security. Recent reviews of studies about therapeutic techniques indicate that the type of treatment applied is less important to successful outcome than how it is exchanged between the clinician and client (O'Neill, 2002b). The positive outcome of any treatment results less from theoretical orientation than from clinical relationship.

Effecting Change in the Helping Services of the USAF Community

Improving the alcohol treatment system is a critical component of ensuring the mental and emotional health of members and the defense integrity of the USAF. Several varieties of programs supporting reflexive changes are proposed. The primary factor of each suggestion is a comprehensive redefinition on the

misperceptions that power holders in the USAF might maintain. New programs should direct a focus towards the implications of members' characteristics identified in the findings. Various service helpers should be provided with new information regarding how such members view their professional helping efforts. Most of the change in new programs should concentrate at the invested authority of the USAF at each base. Change will occur as the attitudes and beliefs of the power structure of leadership reflect their view towards members with the stepfamily and divorce characteristics as well as their view towards the service providers providing alcohol treatment. New program changes should include the members being directly involved, yet with the understanding that the wider education effort is primarily geared towards the leadership and authority and that the learning process is mutual and reciprocal. Members with the characteristics should be made aware that any new helping services will incorporate an awareness of the full involvement of all members into service delivery.

Supporting Efforts to Change the System

Educating USAF helping providers and leaders will lead the change in members' attitudes and beliefs regarding their feelings of personal power and job security. Many of the characteristics found in members sampled are not subject to alteration nor should they be changed if their basic rights are valued. The findings of members' characteristics indicated how some aspects of their living arrangements and career development are stable. Other findings indicated that a propensity to react negatively to stressful situations might accelerate and escalate

the diagnostic process on marital dissolution, possibly as an uneducated reaction to the stepfamily and divorce members. Such interpretations by clinicians could eventually lead toward legal actions against the members such as an early discharge. The education of leadership and helping providers should be directed toward the processes in those areas that unknowingly facilitate such career-stopping legal actions to stepfamily and divorced members.

Changing organizational beliefs requires determining what efforts toward change are feasible. The feasibility of a proposal depends upon using mechanisms presently found in service delivery systems. One type of provider educational program already in place is in-service presentation. More topics covering findings identified from this study could routinely be scripted into multidisciplinary in-service presentations. This type of medical training could be expanded into an interventive template for other helping providers on bases such as chaplains and family support center directors.

The nature of the USAF typically is receptive to change, although as in general populations change is slow. The expansive scope of current changes happening in the USAF seems to indicate that change is the norm rather than the exception. Reorganization of command levels and areas of responsibility as well as stressors of operations tempo are examples of recent large-scale changes. Within the service provision sector of the USAF, a gradual downsizing or rightsizing of medical services occupies much of the long-range planning.

An essential fixture of any proposed change model for stepfamily and divorced members' treatment programs must ensure that the power structure of the dominant group does not maintain the appearance of primary control. Although higher military authority must be respected and supported, military personnel, government contractors, and civil service workers should not occupy a sole seat of vested power. Program authority should be couched in the collaborative efforts of shared power structures. The main emphasis by nonmilitary persons guiding such shared informative programs should focus activities on efforts that improve awareness of military authorities' beliefs and reactions that stem from any member's alcohol incidents.

Supporting Efforts to Change Members' Beliefs

Since the stigma, myths, and unawareness surrounding stepfamily and divorced persons are so pervasive, tangible change in widespread social attitudes will be difficult to realize in this generation. However, specific programs to begin such change should be formed from members experiencing those conditions based on the findings of perceived barriers. Since an underlying theme to the barriers was a perceived lack of autonomy, these members should be included in opportunities to exert their new meanings in forums that can execute changes on base.

Therefore, participatory organizations with discretionary control would equalize the power structures and effect changes expediently, forming base-advisory committees to address the progress of leaders' belief changes and help in

service education for providers and members alike—although at different venues. Committees such as these should be responsible for reviewing at least three barriers identified by the present research.

First, the barrier towards how programs are conducted by type of providers should be addressed. As indicated from the findings, members believed that barriers lay with chaplains, mental health providers, and physicians. Specifically, their lack of comparative awareness with civilian service providers of how stepfamily and divorce issues pertain to members' lives should be examined.

Second, the barrier towards the protection of confidentiality is closely connected to the first barrier and should be addressed. A civilian family member representative should be included in the review committees for each type of helping provider. Including nonactive duty members would require the person to undergo similar training for privacy and confidentiality, but his or her primary purpose would be to act as a monitor of the various other particular committees that discuss members' cases.

Third, the barrier about legal, career, and medical consequences of alcohol infractions should be addressed. Since the members indicated reactivity to current regulations regarding the handling of their alcohol incidents, these types and others should be reviewed to determine where more individualized provisions could be incorporated into regulations, practices, and rank- or skill-level progression. The intent is to foster a more responsive system that focuses on identifying increased stressors and factoring individual constraints into the decision process, which

demonstrates efforts to keep members in the USAF. This type of sensitivity to needs could decrease fear to career and the loss of job security as trust is increased.

Including members' stepfamily and divorce issues in USAF biennial Needs Assessment Survey would help detect the global spread of effectiveness while maintaining anonymity. Conducting further studies on the distribution of stepfamily and divorced members in alcohol treatment would examine whether or not there is a diagnostic trend that programs could have had a negative effect on members' choices. Long-range studies looking at the retention of members with the characteristics might also be considered as a way to validate program effectiveness.

In summary, it is important not to perpetuate the stigma of stepfamily and divorced persons as people with unsolvable problems. The expectations that society places on these people have increased the demand on their abilities to manage such issues effectively. Even if they have managed their issues well, they may be discounted because of what their stigma represents to the power-holding and status-defining (but as yet unaffected) persons of traditional society. Clinical treatments too often assume that traditional treatments may work effectively on nontraditional family situations. More than they do themselves, stepfamilies and divorced persons are people with common ailments who need others to be more informed, educated, and aware of the many difficult challenges set before them. Yet, without the trained response, those stigmatizing social expectations will continue to support their social marginalization.

Implications for Social Work Policy and Practice

The USAF represents a microcosm of mainstream culture. Whatever the primary reasons may be that motivate people to serve voluntarily in the armed forces, the women and men reflect the inculcated values of American culture. Social challenges in the USAF are the same social challenges facing the American population. If the myth and stigma surrounding stepfamily and divorce issues remain unchallenged in the USAF, the same occurrence is possible for the general population. Social workers must expand their clinical knowledge to include those who perceive intuitively or overtly that they are substantively marginalized from society and helping resources and recommit themselves to work with those members to demystify their perceptions.

The prevalence of American stepfamilies and serial divorces requires a substantial shift in policy regarding the many types of clinical treatment. As long as the general regard of stepfamily and divorce continues to influence negatively how these persons and others think of themselves, mental health treatment policy must adapt to these clients' needs. Mental health service provision policies must take care to avoid the common mistake of perpetuating stepfamily and divorce stigma. Some primary U.S. Department of Health organizations, the Substance Abuse and Mental Health Services Administration, the Center for Mental Health Services, and the Center for Substance Abuse Treatment recognize the need for expanding science-based, individualized treatment for people who abuse alcohol (O'Neill, 2001). However, studies measuring the impact of divorce and stepfamily

issues for alcohol abusers materialize slowly. Practitioners in the clinical, research, and policy settings must be more active in examining these challenges.

Since the events of September 11, 2001, social workers' skills and expertise are in demand to meet the needs of the general population (O'Neill, 2002a). As each branch of the armed forces increases the tempo of operations to meet our country's defense requirements, more demands will be made of the service personnel. Maintaining an organizational defense force of dedicated personnel requires the knowledge of those members' needs beyond what they themselves know or what is clinically assumed about stepfamily and divorce circumstances.

Limitations and Future Research

This study was the first of its type to sample USAF members with stepfamily and divorce conditions selected from alcohol treatment programs. Since the design explored and described information not found before, there were limitations that impacted study implications. Since there are more than 189 USAF base locations at which USAF personnel could be assigned, the 3 sites selected may not have been entirely representative. Although efforts were made to achieve larger groups of respondents, the MATS survey and focus group samples were statistically small. Further, although the MATS instrument was used for only the second time and found similar results to the first use, it was applied to a nonrandomly selected sample of voluntary participants from a clinical treatment group. The MATS survey has not previously been shown to predict help-seeking behavior and may not have necessarily measured stepfamily and divorce condition

members or clinical group members as accurately as presumed. Future research might restructure the MATS instrument to further reflect more specific stepfamily and divorce issues.

Finally, this study demonstrated that there are likely many more substantial numbers of USAF members with characteristics that indicate avoidant patterns of not resolving significant life challenges. More studies are needed with a focus specifically on abuse histories as well as on military stepfamily and divorce issues in other service provision areas. This research would increase the breadth of knowledge about the impact on these members and the mission of the USAF.

APPENDIX A

SUBSTANCE ABUSE FILE DATA

SITE & No. / *CRITERIA*			
DEMOGRAPHICS			
Age			
Gender			
Residence (on/off base)			
Children in Home			
Marital H_x			
CAREER			
Rank			
TIS			
TOS			
Duty Determination			
Mobility Status			
AFSC			
CLINICAL			
Contacts/ Appointments			
Immediacy: SF/D			
SF T_x Used			
Suicidality H_x			
Incidences			
Abuse H_x			
D_x			

APPENDIX B

LETTER OF SUPPORT

DATE

MEMORANDUM FOR (Squadron and Office Symbol Providing Support)
ATTENTION:

FROM: AFIT/CI, Univ. of Utah, Graduate School of Social Work

SUBJECT: Support of Proposed Research Study

1. Reference the attached clinical investigation proposal entitled, **"Characteristics of Substance Abuse Service Barriers Among U.S. Air Force Members with Stepfamily or Divorce Histories."** Principal Investigator: Carl S. Miller, Capt, USAF, BSC. If approved, this study would require the support of your department.

2. Your support agreement is required to secure approval of the proposal by the 60th Medical Group Institutional Review Board. Please feel free to contact me at (801) 774-9221 to discuss the proposal.

CARL S. MILLER, Capt, USAF, BSC
AFIT/CIMI, Doctoral Candidate, Univ. of Utah

Attachment:
Research Proposal

1st Ind, **(Insert office symbol)**

TO: SGSE

The (Supporting Unit's Name/Office Symbol) will be able to support this research proposal entitled, **(insert title of the study and investigator's name)**.

SUPPORT UNIT'S FLIGHT CHIEF SIGNATURE BLOCK

APPENDIX C

SOLICITATION MEMO

A USAF RESEARCH STUDY:
SUBSTANCE ABUSE SERVICES and STEPFAMILY/DIVORCE CONDITIONS

TO: Active-Duty Members of Substance Abuse Services

FROM: Carl S. Miller, LCSW, Doctoral Candidate, GSSW, Univ. of Utah

SUBJECT: Call for Research Participants

I am conducting a study concerning USAF stepfamily challenges. Specifically, I want to better understand information I previously found indicating a larger than expected stepfamily representation in USAF Outpatient Substance Abuse Clinics.

I am looking for participants who have had voluntary or involuntary services and are willing to complete a survey and/or meet in a one-time focus group to be held at a site on base. The group should last for about 60-90 minutes and will be audio-recorded for later transcription and analysis. Before the beginning of the group, I would like you to complete a survey related to the study topic, which should take about 15-20 minutes.

Criteria for participation are:
Primary Study Group;

1. An adult active-duty member in or from a stepfamily.
2. Remarried or Divorced and a Stepparent.
3. Or had parents who were divorced or remarried at any time.
4. Have received or are receiving Substance Abuse services for an alcohol incident.

Secondary Study Group;

1. An adult active-duty member in or from a traditional or nuclear family.
2. Have never been remarried or divorced or a stepparent.
3. Or never had parents who were divorced or remarried at any time.
4. Have received or are receiving Substance Abuse services for an alcohol incident.

If you are willing to participate in this important study, please contact your treatment provider. You will be assigned to either the Primary or Secondary group and informed of when the meeting will occur. Questions regarding the conduct of this study may be forwarded to LTC Kevin Blakley, Clinical Director of the Travis AFB LSSC (707) 423-5174, Maj Camille Gaudet, Chief of Travis AFB Substance Abuse Clinic (707) 423-2350, or myself at (801) 774-9221. For protection of your privacy, please do not leave your name on any voice-mail or message machines, just ask to have your call returned.

I appreciate your time in reading this request, your interest in this undeveloped area, and your participation if choose to do so. Best wishes in all you do.

Sincerely,
CARL S. MILLER
Air Force Institute of Technology

APPENDIX D

MILITARY SURVEY OF ATTITUDES

TOWARDS SERVICES

MILITARY SURVEY OF ATTITUDES TOWARDS SERVICES

The USAF provides a variety of services that are intended to help members and their families. Whether or not USAF members actually believe these services are helpful is vital if they are going to be changed or improved. This is why you are being asked to fill out this survey. Please respond to each question from **YOUR** point of view. **Again, your participation is totally voluntary and responses are strictly private and confidential.**

Please circle responses and fill blanks as appropriate:

Rank: E1-E4 E5-E6 E7-E9 O1-O3 O4+

Age:____ **Sex:** Female Male

Current Marital Status: Married Divorced Never Married Other:_____

Highest Educational Level Attained: High School Some College College Degree Graduate Degree
Other:_____

Race/Ethnicity:_____ **First Number of Your AFSC:**_____

This set of questions [1-21] concerns "personal problems" or serious troubles such as depression, thoughts of suicide, abusing alcohol, or physical fights with a spouse or friend.

For each of the following statements [6-17], fill in the blank with [one] each of the four selections and circle the degree you agree with the statement [1-5] using this scale:

1=Disagree 2=Partly Disagree 3=Partly Agree 4=Agree

For personal problems or serious troubles, I think:

		Disagree Agree
1. USAF members' careers will be hurt if they talk with military.....	Chaplains	1 2 3 4
	Mental Health Professionals	1 2 3 4
	Commanders/First Sergeants	1 2 3 4
	Medical Doctors	1 2 3 4
	Friends	1 2 3 4
2. USAF members' problems are kept confidential (private) when they talk to.....	Chaplains	1 2 3 4
	Mental Health Professionals	1 2 3 4
	Commanders/First Sergeants	1 2 3 4
	Medical Doctors	1 2 3 4
	Friends	1 2 3 4
3. I have a lot of faith in the skills of the military.....	Chaplains	1 2 3 4
	Mental Health Professionals	1 2 3 4
	Commanders/First Sergeants	1 2 3 4
	Medical Doctors	1 2 3 4
	Friends	1 2 3 4
4. USAF members would be embarrassed if others knew they had seen military.....	Chaplains	1 2 3 4
	Mental Health Professionals	1 2 3 4
	Commanders/First Sergeants	1 2 3 4
	Medical Doctors	1 2 3 4
	Friends	1 2 3 4
5. USAF members would feel weak if they talked to military.....	Chaplains	1 2 3 4
	Mental Health Professionals	1 2 3 4
	Commanders/First Sergeants	1 2 3 4
	Medical Doctors	1 2 3 4
	Friends	1 2 3 4

(PLEASE CONTINUE ON BACK)

Please use the following numbers to indicate the level you agree or disagree with the following statement:

1=Disagree
2=Partly Disagree
3=Partly Agree
4=Agree

___6. If I thought I was having a nervous breakdown, my first thought would be to get professional help.

___7. Talking to a mental health professional is a poor way to get rid of emotional problems.

___8. If I was having a serious emotional problem, I would be confident that a mental health professional could help.

___9. I admire people who are willing to cope with their problems and fears without resorting to professional help.

___10. I would want to see a mental health professional if I was worried or upset for a long period of time.

___11. I might want to have mental health counseling in the future.

___12. A person with an emotional problem will solve it with professional help.

___13. Considering the time and expense involved in mental health counseling, I doubt it would help a person like me.

___14. A person should work out his or her personal problems and get mental health counseling only as a last resort.

___15. Personal and emotional problems tend to work out by themselves.

___16. The USAF has plenty of help for me if I have any personal or emotional problems.

___17. I think that USAF mental health professionals often "make a big deal" out of small matters.

If you would like to comment on any of the questions or your answers, please do so below:

Circle Yes or No.

18. Have you ever voluntarily talked to a military mental health professional about any problem of yours? Yes No

19. Have you ever been forced or coerced into talking to a military mental health professional? Yes No

20. If you answered "no" to questions 18 and 19, then have you ever seriously considered seeking military mental health services for yourself? Yes No

21. Have you ever seen a civilian mental health professional because you didn't want to go to the base mental health clinic? Yes No

If you would like to comment on any of the questions or your answers, please do so below:

Note. Attitudinal and Perceptual Barriers to Accessing Mental Health Services Among Members of the U.S. Air Force (pp. 158-159) by F. P. Stone, 1998, Doctoral dissertation, University of Utah, Salt Lake City.

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